SURGICAL ROOT CANAL (APICOECTOMY) CONSENT

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: Infection or non-healing lesion of root tip(s) tooth # *To be determined*

Procedure: Remove root tip(s) (apicoectomy) of tooth # *To be determined*

Alternative options: No treatment, extract tooth, attempt to retreat root canal.

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:
    - Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
    - Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
    - Changes of the appearance of the teeth;
    - Discoloration and appearance changes of the gum tissue;
    - An opening may occur from the mouth into the nasal or sinus cavities;
    - Failure of the procedure requiring removal of the tooth.

    BONE GRAFT (if done)

    The graft will be will be banked bone or bone substitute and will be place adjacent to the implant with or without a membrane. I understand this graft involves additional potential risks, including but not limited to:
    - Nerve injury where the graft is placed resulting in altered or loss of sensation, numbness, pain, or changed feeling in the lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
    - Failure, loss, infection, or rejection of the graft or membranes used to contain the graft;

- An opening may occur from the mouth into the nasal or sinus cavities;
- I understand there is a rare chance of disease spread from the processed bone.

2. I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:
    - Allergic or adverse reactions to medications or materials;
    - Pain, swelling, redness, irritation, numbness and/or bruising in the area where the needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;
    - Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is over;
    - Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death;

3. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

4. Patient's Responsibilities
    - I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).
    - I understand the use of tobacco and alcohol is detrimental to the success of my treatment.
    - I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.
    - I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.
    - I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.