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INFORMED CONSENT
Apicoectomy Treatment

Patient Name: _____ **Date:** _____

DIAGNOSIS: _____

Patient's initials required

_____ Twisted, curved, accessory or blocked canals may prevent removal of all inflamed or infected pulp/nerve during root canal treatment. Since leaving any pulp/nerve in the root canal may cause your symptoms to continue or worsen, this might require an additional procedure called an **Apicoectomy**. Through a small opening cut in the gums and surrounding bone, any infected tissue is removed and the root canal is sealed, which is referred to as a retro filling procedure. An Apicoectomy may also be required if your symptoms continue after root canal therapy and the tooth does not heal.

Benefits of Apicoectomy, Not Limited to the Following:

_____ Apicoectomy treatment is intended to help you keep your tooth, allowing you to maintain your natural bite and the healthy functioning of your jaw. This treatment has been recommended to relieve the symptoms of the diagnosis described above.

Risks of Apicoectomy, Not Limited to the Following:

_____ I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible that infection may accompany treatment and must be treated with antibiotics. I will immediately contact the office if my condition worsens or if I experience fever, chills, sweats or numbness.

_____ I understand that I may receive a local anesthetic and/or other medication. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

_____ I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking, which are: _____

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. I must notify your office if this or other concerns arise.

_____ I understand that Apicoectomy treatment may not relieve all symptoms. The presence of gum disease can increase the chance of losing a tooth even though Apicoectomy treatment was successful. If extraction of the tooth is required, denture, bridge or implant treatment will be discussed.

Consequences if Apicoectomy is not Administered, Not Limited to the Following:

_____ I understand that if I do not have Apicoectomy treatment, my discomfort may continue. I may face the risk of an infection that could develop into a serious, potentially life-threatening infection abscesses in the tissue and bone surrounding my teeth and eventually, the loss of my tooth and/or adjacent teeth.

Alternative Treatments if Apicoectomy is Not the Only Solution, Not Limited to the Following:

_____ I understand that depending on my diagnosis, alternatives to Apicoectomy treatment may exist which involve other disciplines in dentistry. Extracting my tooth is the most common alternative to Apicoectomy treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an *implant.* My dentist has discussed with me the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures, their risks, benefits and costs.

Alternatives discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

☐ I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

Patient or Patient's Representative's Signature _____ Date _____

I attest that I have discussed the risks, benefits, consequences and alternatives of Apicoectomy treatment with _____(Patient's name) who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____ _____

Dentist's Signature Date

_____ _____

Witness's Signature Date