ENDODONTIC EXCELLENCE
WHERE CARING IS OUR SPECIALTY

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RECORD OF DISCUSSION AND INFORMED CONSENT FOR APICOECTOM

TOOTH #_____

I understand the purpose of this treatment is to treat and possibly correct my diseased tooth and/or tissues in my mouth. An apicoectomy is a *root-end resection with root-end filling*. This is the most common endodontic surgery. It is recommended when inflammation or infection persists in the bony area around your tooth following endodontic therapy. During surgery an opening is made in the gum tissue near the affected tooth and the inflamed or infected tissue is removed. The very end of the root is removed, and a small filling may be placed to attempt to seal the end of the root. During the procedure, your root(s) will be checked for fracture. If a fracture is found, the affected root or possibly the entire tooth may have to be removed.

Occasionally the supporting bone around your tooth is lost. Significant loss of supporting bone may require guided tissue regeneration. During surgery, a material is placed around your tooth and covered by your gums. The barrier membrane keeps the gingiva away and provides a space for healthy new fibers which connect to the tooth as well as bone regrowth. A few stitches are placed to help the healing process and are removed in several days. If an adequate amount of inflamed or infected tissue is obtained from the site, it will be sent to for examination under a microscope (biopsy). This is billed separately by the biopsy center. You will be informed at the time the surgery is completed.

I understand that apicoectomies includes possible inherent risks such as, but not limited to the following:

- Gingival recession: Recession of gums away from the crown, exposing more tooth/root, can occur. Crown margins or roots may become visible when smiling or talking. This may require gum or bone corrective surgery.
- Injury to the nerves: This would include injuries causing numbness of the lips; tongue; and tissues of the mouth; and/or cheeks or face. This numbness which could occur may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
- Bleeding, bruising, swelling: Bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.
- Infection: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, infections may occur postoperatively. At times these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention should be received as soon as possible.
- Maxillary Sinus or Mandibular Canal Involvement: In some cases, the roots of the teeth that are going to be surgically treated lie close to anatomic structures such as the maxillary sinus, mandibular canal, or mental nerve foramen (opening in the jaw bone), and these anatomical structures may be traumatized during the surgical procedure involved with removing the root-end of the infected teeth. Such events can cause the numbness described above.
- Injury to adjacent teeth or adjacent roots: There is a possibility of injury to an adjacent tooth or roots of teeth during the procedure. If an adjacent tooth is inadvertently damaged during the surgical procedures, conventional endodontic treatment, endodontic surgery, or extraction of the affected tooth may be required.
- Unusual reactions to medications given or prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions.

Even though the surgical procedure is properly performed, there exists the possibility that the attempt to preserve the tooth will fail due to the tooth and tissues not responding as they should, necessitating extraction of the tooth. I understand the proposed treatment may not be curative and/or successful to my complete satisfaction. Failure may result despite treatment and may require additional treatment and/or extraction of the tooth. I understand that small number of patients do not respond successfully endodontic surgery, and in such cases, the involved teeth may be lost. The success of endodontic surgery procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption,

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clenching and grinding of teeth, inadequate oral hygiene, and medications that may taking and their unique conditions. Endodontic surgery may not be successful in preserving function or appearance.

I understand there are **alternatives to surgical endodontic therapy.** They include but may not be limited to:

1) *Extraction followed by a bridge, partial denture, or implant to fill the space.*

2) *Extraction with nothing to fill the space.* This may result in shifting of teeth, change in bite, periodontal disease.

3) *No treatment at all.* My present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to: pain, swelling, infection, cyst formation, loss of supporting bone around my teeth, and premature loss of teeth.

I understand that I am to **return to this office for suture removal within 10 days, then periodically for re-evaluation visits, for at least 2 years.** The purpose of these visits is to monitor the endodontic treatment for healing and recommend further treatment as may be needed. If I do nothing, pain, severe abscess or disabling infection can result. Treated teeth can still decay. As with other teeth, the proper care of these teeth consists of good home care, sensible diet, and periodic check-ups. It is my responsibility to seek attention should any undue circumstances occur postoperatively, and I shall diligently follow any preoperative and postoperative instructions given me.

I have been given the opportunity to ask any questions regarding the nature and purpose of endodontic surgery and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment is hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to be concerning the results. By signing this document, I am freely giving my consent to allow and authorize doctor(s), and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental condition(s), including prescribing and administering any and all anesthetics and/or medications**.**

I have read the above and fully understand the consent that I am signing.

Signature: _____Printed Name: _____Date:_____