

Consent for Apicoectomy

Diagnosis: After a careful oral examination and study of my dental condition, my dentist has advised me I have an infection associated with a tooth that has had a root canal therapy. If untreated, this infection can cause me to lose my tooth and can have other adverse consequences.

Recommended Treatment: In order to treat this condition, my dentist has recommended that my treatment include endodontic (apico) surgery. I understand that a local anesthetic will be administered to me as part of my treatment. I further understand that antibiotics may be prescribed as deemed necessary for treatment of my periodontal condition. I also understand that my dentist performing this procedure does not limit his practice to endodontics as a specialty.

During this procedure, my gum will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed and the root end will be thoroughly cleaned and filled in with a restorative material. Bone regenerative material may be placed in the treatment area. My gum will then be sutured back to position, and a periodontal dressing or bandage may be placed.

I further understand that unforeseen conditions may call for a modifications or change from the anticipated surgical plan. These may include, but not limited to (1) extraction of hopeless teeth to enhance healing of adjacent teeth,(2) the removal of a hopeless root of multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of endodontic surgery is to reduce infection and inflammation associated with an infected root or roots, and to restore my bone and root end to the best extent possible. The surgery is intened to help me keep my teeth in the operated areas and avoid the need for extraction.

Principal Risks and Complications: I understand that small number of patients do not respond successfully endodontic surgery, and in such cases, the involved teeth may be lost. Endodontic surgery may not be successful in preserving function or appearance. Because each patients condition is unique, long term success may not occur.

I understand that complications may result from the surgery, drugs, or anesthetics. These complications include, but not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Transient but on occasion permanent increased tooth looseness, cracking of tooth, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, allergic reaction, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum or bore will heal. I understand that there may be need for a second procedure if the initial results are not satisfactory. In addition, the success of endodontic surgery procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that may taking. To my knowledge, I have

Tischler Dental
121 Route 375
Woodstock NY 12498

(845)679-3706
mai/@tischlerdental.com
www.tischlerdental.com

reported to my dentist any prior drug reactions, allergies, diseases, or conditions which might in any way relate to this surgical procedure. I understand diligence in providing the personal daily care recommended by my dentist and taking all prescribed medications are important to the ultimate success of the procedure.

No Warranty or guarantee: I here by acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a dentist cannot predict certainty of success. There is risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

I have been fully informed of the nature of endodontic surgery, the procedure to be utilized, the risk and benefits of endodontic surgery, the alternative treatments available and the necessity for follow-up and self care. I have had the opportunity to ask questions I may have in connection with the treatment and discuss my concerns with my dentist. After thorough deliberation, I hereby consent to the performance of endodontic surgery as presented to me during consultation and in the presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my dentist.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT.