

## INFORMED CONSENT FOR ENDODONTIC SURGERY

This is the consent for Dr. \_\_\_\_\_ to perform the treatment/procedure as follows:

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— **ROOT END RESECTION** with root end filling also known as apicoectomy with retrofill. This is the most common endodontic surgery. It is recommended when inflammation or infection persists in the bony area around the 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 in attempt to seal the end of the root. During the procedure, the root(s) will be checked for fractures. If a fracture is found, the affected root or possibly the entire tooth may have to be removed. Significant loss of supporting bone may require guided tissue regeneration.

— **ROOT AMPUTATION** is recommended when severe gum disease or a severe crack in the root is observed in a tooth with more than one root that has had previous endodontic therapy. During the surgery, an opening is made in the gum tissue and the entire affected root is removed.

A few stitches are placed to help the healing process and are removed in several days. If an adequate amount of inflamed or infected is obtained from the site, it will be sent to our labs for examination under a microscope (biopsy). This is billed separately by the Oral Pathology Service. You will be informed of this process at the time the surgery is completed.

*I understand that the purpose of this treatment is treat and possibly correct my diseased mouth and/or tissues in my mouth.*

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

- 1) 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.
- 2) Extraction with nothing to fill the space. This may result in shifting of teeth, change in occlusion (bite), or periodontal disease.
- 3) Extraction followed by a bridge, partial denture, or implant to fill the space.
- 4) Retreatment (of previous unsuccessful endodontic therapy.)

*I understand that the following conditions, side-effects and complications have been known to be associated with or follow this type of treatment and anesthesia but are not limited to:*

- 1) Pain and swelling of the area following treatment. Often the tooth will become mobile, but usually tightens after several weeks.
- 2) Prolonged and heavy bleeding, infection, bruising (temporary discoloration of tissues), and delayed healing.
- 3) Recession of gums away from the crown exposing more tooth/root. Crown margins may become visible.
- 4) Prolonged and heavy bleeding, infection, bruising (temporary discoloration of tissues), and delayed healing.
- 5) Sinus opening, infections, and/or complications (upper teeth).
- 6) Loosening or injury to adjacent teeth and dental restorations. root fractures or bone splinters.
- 7) Displacement of teeth or foreign bodies into nearby tissues, spaces and cavities.

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- 8) Spasm or cramps of the neck, facial and jaw muscles.
- 9) Tightness or injury to jaw joints, temporary restricted mouth opening, change in occlusion (bite).
- 10) Medication, anesthetic and injection reactions, or other unexpected conditions, side effects and complication.

— I GIVE CONSENT for the administration of local anesthetics which are commonly used in dentistry to prevent pain. Risks of local anesthetics include:

- Allergic reaction
- Fainting
- Infection
- Hematoma (deep bruising, swelling and discoloration)
- Prolonged or permanent numbness

*I understand that the above-mentioned conditions, side-effects, complications and risks occur in frequencies that range from common (e.g. pain and swelling), to occasional (e.g. infection), to extremely rare (e.g. fractures and permanent numbness). I understand that if any of these (or other) conditions, side-effects, complications and risks arise, there may be need for additional treatment, interference of employment obligations and additional expense.*

No guarantee of success or perfect result has been given to me. I understand that 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. The diagnosis, method and manner of the proposed procedure(s), the nature and purpose, prognosis, risks of treatment and feasible alternatives have been explained to me. I fully understand this consent form and that it does not encompass the entire discussion with the doctor regarding the proposed treatment. I have had the opportunity to question the doctor concerning the nature of treatment, the inherent risks of treatment and the alternatives to this treatment. I consent to surgical endodontic therapy and to the administration of local anesthetic and pain medication as deemed necessary.

I am medically and physically competent to understand this form. I have not taken any mood or mind-altering drugs during the twelve hours prior to signing this consent.

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Patient (or Legal Guardian) Date

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Doctor (Signature) Date