ENDODONTIC EXCELLENCE
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CONSENT FORM FOR APICOECTOMY

Tooth #: _____

This consent form explains the risks, benefits, and alternatives to apicoectomy microsurgery, ensuring that you are fully informed. This procedure aims to treat and potentially correct disease or infection in my tooth and surrounding tissues.

During the procedure, an opening will be made in the gum tissue near the affected tooth to remove the inflamed or infected tissue and the very end of the root. A small filling may be placed to seal the end of the root. If a fracture is discovered in the root, additional treatment, including possible removal of the tooth, may be necessary.

Treatment Alternatives and No Treatment Consequences

Alternatives to an apicoectomy include:

- **Extraction** of the tooth, followed by: a bridge, partial denture, or implant to fill the space. No replacement may result in shifting teeth, changes in bite, or periodontal disease.
- **No treatment**, which may lead to worsening conditions, such as pain, swelling, infection, cyst formation, loss of bone, and premature loss of teeth.

Risks and Consequences

Apicoectomy involves inherent risks, including but not limited to:

- **Gingival recession**, exposing more tooth/root and requiring potential corrective surgery.
- **Infection**, possibly leading to serious complications.
- **Maxillary sinus or mandibular canal involvement**, potentially causing temporary or permanent numbness in the lips, tongue, cheeks, or face, or requiring additional procedures.
- **Injury to adjacent teeth or roots**, necessitating further treatment.
- **Reactions to medications**, varying from mild to severe.

Additional risks include:

- **Post-operative bleeding and pain**.
- **Bleeding, bruising, and swelling**, which may require medical attention if severe.
- **Removal of bone** during the procedure.
- **Jaw discomfort:** Long appointments may result in jaw muscle soreness, particularly if you have pre-existing TMD
- **Antibiotics:** May interfere with birth control effectiveness. Notify the office of any side effects
- **Pain medications:** May cause drowsiness. Avoid operating vehicles or machinery while taking them.

Post-Treatment Care

I understand that I must return to the office for suture removal within 10 days and periodic evaluations for at least 2 years to monitor healing. Proper care and regular dental checkups are essential to maintain treatment success.

Acknowledgment and Consent

I understand the proposed procedure, its risks, benefits, and alternatives. I acknowledge that no guarantees have been made regarding the outcome. By signing this form, I acknowledge and accept the risks and give my consent for Dr. _____ and their team to perform the recommended Apicoectomy and administer necessary anesthetics.

I also give permission for photography, video, and x-rays for administrative, teaching, and educational purposes.

Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____