Roseville Smiles Family Dentistry

Discussion and Informed Consent for Apicoectomy Treatment

Patient Name:_____ Date: _____

Diagnosis:_____

Treatment:_____

Apicoectomy is a form of root canal treatment, or jaw surgery, intended to promote preserving teeth that have been subjected to decay or trauma.

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 retrofilling procedure. An apicoectomy may also be required if your symptoms continue after root canal therapy and the tooth does not heal. In some cases, tissue is removed and may require a biopsy, at an additional cost.

Benefits of Apicoectomy, Not Limited to the Following:

_____ Apicoectomy treatment is intended to help you keep your tooth, allowing you to maintain your bite with natural teeth 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 temporary bruising of my face, bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible that infection may accompany treatment and may be treated with antibiotics. Temporary or permanent numbness, or painful nerve conditions, may occur. I will immediately contact the office if my condition worsens or if I experience fever, chills, sweats, numbness, sinus problems, severe pain or swelling.

_____ I understand that other complications such as sinus opening, infections, displacement of teeth or foreign bodies into the sinuses, tissues, spaces and cavities may occur, requiring additional surgery, at additional costs.

_____ I understand that since a portion of the root end is removed, the root will be shorter. As a result, in some cases the tooth may become temporarily or permanently loose.

_____ I understand that there is a possibility of injury to an adjacent tooth or to roots of teeth during the procedure. If an adjacent tooth or roots of teeth are injured or otherwise damaged during the surgical procedure, conventional endodontic treatment, endodontic surgery, or extraction may be required.

_____ I understand that 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 an additional gum and or bone surgery to correct.

_____ I understand that surgery to expose the root can require removal of surrounding bone to gain access. As a result, bone grafting may be required during the surgery, which may incur an additional cost. This may also be necessary if infection has caused a resulted bone loss.

_____ I understand that I may receive a local anesthetic and/or other medication to assist in my comfort during treatment. 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, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar 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.* As stated above, choosing not to treat the condition is an option with the risks and consequences. Retreatment (re-doing) the root canal may be an alternative. 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.

Check only one of the boxes below that applies to you:

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

or

□ 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 and willingly gives their consent or refusal as noted above.

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____