_____ _____
Patient's Name Today's Date

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR **BEFORE** INITIALING.

____ 1. My condition has been explained to me as:
_____

____ 2. The procedure(s) necessary to treat the condition has been explained to me as:
- Removal of the end of the tooth root(s) (**Apicoectomy**)
- Placement of a filling at the end of the root(s) (**Retrograde filling**)
- Removal of an entire root of a multi-rooted tooth (**Hemisection**)
- Extraction of tooth, completion root canal fillings, apicoectomy and/or retrograde fillings and replacing the tooth back into its socket (**Intentional Replantation**)
- Use of bone grafting material.
- Other: _____

___ 3. I have been informed of possible alternate methods of treatment (if any) including :
_____
_____
I understand that these other forms of treatment, or no treatment at all, are choices I have and the risks of those choices have been presented to me.

4. **Risks of Apicoectomy and Retrograde Filling procedures:** My doctor has explained to me that there are certain risks and side effects associated with my proposed treatment and, in this specific instance, they include, but are not limited to:

____A. Post-operative discomfort and swelling requiring several days of at-home recovery.
____B. Prolonged or heavy bleeding that may require additional treatment.
____C. Injury or damage to the blood supply of teeth adjacent to the surgical site that may cause loss of tissue, require additional root canal treatment to those teeth, or even result in loss of an injured tooth.
____D. Post-operative infection that may adversely affect healing and require additional treatment.
____E. Scarring at the site of incisions inside the mouth, which in rare cases may also have cosmetic effects on the skin.
____F. Injury to sensory nerves in either donor or recipient sites, resulting in numbness, tingling, pain, or other sensory disturbances in the chin, lip, cheek, face, teeth, gums or tongue, and which may persist for several weeks or months, or in rare cases may be permanent.
____G. Fracture of the tooth, most likely requiring its removal.
____H. Leaving a small piece of root in place when its removal would require extensive surgery.
____I. Unusual or adverse responses to drugs and medicines used in the procedure.
____J. Discoloration (tattooing) of gum tissue from the retrograde filling material.
____K. Inability to gain total access to the root canals, possibly compromising the result.
____L Penetration of the sinus, possibly resulting in bleeding from the nose and/or prolonged sinus problems that may require additional treatment.
____M. Separation of the tip of fine instruments used in root canal therapy and inability to retrieve that instrument from the tooth, possibly compromising the planned result.

 CONSENT FOR TOOTH ROOT SURGERY

5. **Additional risks if Hemisection is planned:**
___A. Some instability and/or mobility (looseness) of the tooth, usually temporary in nature, but which could require further care..
___B. Fracture of the tooth, usually resulting in its loss.
___C. Longer healing time.
___D. Discovery of other conditions at surgery that may compromise the planned procedure.

6. **Additional Risks if Intentional Replantation is planned:**
___A. Fracture of or damage to the tooth during extraction.
___B. Fracture of the bony socket walls during extraction, possibly resulting in ability to complete the planned procedure.
___C. Failure of the reimplanted tooth to integrate (bond securely to bone) and eventual failure to heal, usually requiring extraction.

7. **Additional Risks if Grafting is planned:**
____A. *BONE GRAFTING* involves taking a segment (or particles) of bone and transferring it to the site(s) of root surgery. The usual donor site is from the lower jaw on either/ both sides.
____B. Failure of the graft to integrate with surrounding natural bone, loss of vitality or other unexpected loss of the bone graft.
____C. Other forms of synthetic bone may be used to supplement natural bone graft. These particles may also become devitalized and be lost, often over some period of time.
____D. Biologic/synthetic membranes may be used to contain and protect the graft. Some may require a second procedure to remove them; or some may be unexpectedly lost, in which case the graft may be adversely affected.
____E. Metallic screws or plates may be used to fix the graft or membrane in place. These may be spontaneously lost or require a later procedure to remove them.

____8. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the planned procedure(s). I authorize my doctor and staff to use professional judgement to perform such additional procedures that are necessary and desirable to complete my surgery.

____9. The anesthetic I have chosen for my surgery is: □ Local Anesthesia □ Local anesthesia with Nitrous/Oxide/Oxygen Analgesia □ Local Anesthesia with Oral Premedication □ Local Anesthesia with Intravenous Sedation □ General anesthesia

____10. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation (phlebitis) at the site of an intravenous injection that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, does carry the rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

____11. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:**
A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
B. During recovery time you should not drive, operate complicated machinery or devices, or make important business decisions.

C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE **NOTHING** TO EAT OR DRINK FOR 6 HOURS PRIOR TO YOUR ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**

D. **However**, it is important to take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by us, **using only a small sip of water.**

____9. It has been explained to me, and I understand that perfect results cannot be guaranteed.

____10. I have read and fully understand this consent for surgery, and have had all questions answered prior to my initials or signature.

PLEASE ASK YOUR DOCTOR IF YOU HAVE QUESTIONS CONCERNING THIS CONSENT.

_____

Patient or Legal Guardian's Signature Date

_____

Doctor's Signature Date

_____

Witness' Signature Date