

CONSENT FOR TOOTH ROOT SURGERY

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Patient's Name

Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

My diagnosis is: _____

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 tooth that has several roots (**Hemisection**)
- Pulling the tooth, completion of root canal fillings, apicoectomy and/or retrograde fillings and putting the tooth back into its socket (**Intentional Replantation**)
- Use of bone grafting material.
- Other: _____

Alternative treatment: methods include: _____

All surgeries have some risks. They include the following and others:

- ____A. Post-operative pain and swelling needing several days of at-home recovery.
- ____B. Prolonged or heavy bleeding that may need more treatment.
- ____C. Injury or damage to tooth roots that are close by. I may later need root canal treatment, or even lose certain teeth.
- ____D. I may get an infection after the procedure that may need more treatment.
- ____E. Scarring at the site of incisions inside the mouth, which rarely may also have cosmetic effects on the skin.
- ____F. The roots of the lower teeth might be very close to the nerve. After the surgery, there might be pain or a numb feeling in the chin, lip, cheek, gums, teeth or tongue. It is possible that I might lose my sense of taste. These things might last for weeks or months. They can be permanent, but this rarely happens.
- ____G. If, during the course of the procedure, there are surgical findings that indicate the tooth cannot be saved, I agree to have the tooth removed..
- ____H. Leaving a small piece of root in place if doing a much larger surgery would be needed to remove it.
- ____I. Unusual or allergic responses to medicines used in the procedure.
- ____J. Discoloration (tattooing) of gum tissue from the retrograde filling material.

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- M. The tip of a tool can possibly break off. If you are unable to take the tip out of the tooth, the result may not be as planned.

Additional risks if Hemisection is planned:

- A. Some looseness of the remaining tooth. This is usually temporary, but might need more care or extraction of the tooth.
- B. Fracture of the tooth, usually resulting in its loss.
- C. Longer healing time.
- D. Discovery of other conditions at surgery that may prevent us from doing the planned procedure.

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 inability to complete the planned procedure.
- C. Failure of the re-implanted tooth to bond securely to bone. The tooth may fail to heal, usually resulting in needing to pull the tooth.

Additional Risks if Grafting is planned:

- A. *BONE GRAFTING* involves taking a segment or particles of bone and transferring them to the site(s) of root surgery. You usually take the bone 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.

Information For Female Patients:

- A. I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to discuss with my personal doctor using other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

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ANESTHESIA

I have had the opportunity to speak with Dr. _____ about my options for anesthesia. These options include Local Anesthesia, Nitrous Oxide/Oxygen Analgesia with Local Anesthesia, Oral Medication with Local Anesthesia, Intravenous Sedation, or Deep Sedation/General Anesthesia. After this discussion, I have chosen to have _____ as my anesthesia. I understand the risks and potential complications of anesthesia to include:

- _____A. Discomfort, swelling or bruising where the drugs are placed into a vein.
- _____B. Vein irritation, called phlebitis, where the drugs are placed into a vein. Sometimes this may grow to a level of discomfort or disability where it may be difficult to move my arm or hand. Sometimes medication or other treatment may be needed.
- _____C. Nerves travel next to the blood vessels where the drugs are placed into a vein. If the needle hits a nerve or if drugs or fluid leaks out of the vessel around a nerve, I may have numbness or pain in the nerve where it runs along the arm. Usually the numbness or pain goes away, but in some cases, it may be permanent.
- _____D. Allergic reactions (previously unknown) to any of the medications used.
- _____E. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be needed for relief.
- _____F. Conscious sedation and deep sedation/general anesthesia are serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.
- _____G. In situations where a breathing tube is used, I may have a sore throat, hoarseness or voice change.

MY OBLIGATIONS:

- _____H. Because anesthetic or sedative medications (including oral premedication) cause drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until I am recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.

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- ____ I. During recovery time (normally 24 hours), I should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.
- ____ J. I must have a completely empty stomach. It is vital that I have **NOTHING TO EAT OR DRINK** for **six (6) hours** prior to my treatment. **TO DO OTHERWISE MAY BE LIFE-THREATENING.**
- ____ K. **Unless instructed otherwise**, it is important that I take any regular medications (high blood pressure, antibiotics, etc.) or any medicines given to me by my surgeon **using only small sips of water.**

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to surgery and chosen anesthesia. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient or Legal Guardian's Signature

Date

Doctor's Signature

Date

Witness' Signature

Date