253 DENTAL CARE

Dentistry Dedicated to Excellence

Consent for Apicoectomy Root Canal Surgery

I, _____ ,hereby authorize Dr. Mark Walker to perform the following procedure:_____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment. The doctor has also informed me that there are certain potential risks associated with this treatment plan or procedure that may occur despite the experience and skill of the doctor.

I UNDERSTAND that APICOECTOMY ROOT CANAL SURGERY includes possible inherent risks such as, but not limited to the following and I agree to accept any and all such risks:

1. Injury to the nerves: This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness could occur and may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

2. Bleeding, bruising, swelling: Bleeding may last several hours. If bleeding is profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time

3. Infection: No matter how carefully surgical sterility is maintained, it is possible, due to existing non-sterile or infected oral environment, infections may occur post operatively. At times, infections may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon possible should be received.

4. Sinus or Mandibular Canal Involvement: In some cases, the roots of the teeth that are going to be apically treated lie in closer apposition to the Maxillary Sinuses or to the Mandibular Canal, including the Mental Foramen than they appear to be radiographically. Even though a rare occurrence, there is a slight possibility that the Maxillary Sinus or the Mandibular Canal may be perforated, or the nerves emanating from the Mental Foramen may be traumatized during the surgical procedure involved with removing the apices of the infected teeth.

5. Injury to adjacent teeth or adjacent roots: 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 inadvertently nicked or otherwise damaged during the surgical procedures, conventional endodontic treatment, endodontic surgery, or extraction may be required.
6. Failure: Even though the surgical procedure is properly performed, there exists the

possibility that the attempt to preserve the tooth will fail due to the tooth and tissues not responding as they should, thereby necessitating extraction of the tooth.

7. Follow-up Treatment: It is absolutely necessary following apicoectomy root canal surgery to have regular periodic examinations. The patient must assume the responsibility to make appointments and report as instructed by the treating dentist(s) or staff.

8. Unusual reactions to medications given or prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

9. Bisphosphonate drug risks: For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone, including sinus lifts and/or bone grafts.

10. I recognize that it is my responsibility to fully inform my treating dentist(s) of the condition of my health and any and all problems thereto. It is also my responsibility to timely seek attention should any undue circumstances occur postoperatively. I agree to diligently comply with any and all preoperative and postoperative instructions given me.

I have been given the opportunity to ask any questions regarding the nature and purpose of this treatment known as **Endodontic Apicoectomy Surgery** and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. Walker to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize Dr. Walker to perform such procedures when, in their professional judgment, they are necessary. I also verify that I have provided a complete and accurate medical history that includes all medications, drug use, allergies, previous surgeries, and pregnancyinformation and history.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase the effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask the doctor or staff if you have any questions.

_____ _____

Patient, parent or guardian Date

_____ _____

Doctor Date

32114 1st Avenue South #200 · Federal Way, Washington 98003
Phone (253) 838-9333 · Fax (253) 517-8766