Center for Oral and Facial Surgery
Associates in Oral & Maxillofacial Surgery, P.C.

CONSENT FOR APICOECTOMY & ANESTHESIA

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

Patient Name:_____ Account #: _____

I hereby authorize Dr._____and staff to perform the following

procedure:_____and to administer the anesthesia I have chosen, which is:

☐ local anesthesia ☐ nitrous oxide/oxygen analgesia ☐ intravenous sedation ☐ general anesthesia

1. 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 that I have and the risks of those choices have been presented to me.

2. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

   A. Infection requiring incision and drainage and possible extraction of the tooth
   B. If the end of the root protrudes into the maxillary sinus and infection occurs, additional procedures may be required to eliminate the sinusitis. (this may require hospitalization and sinus operations)
   C. If the apical surgery is required on a lower tooth, involvement of the inferior alveolar nerve is a possibility. If this nerve is injured or bruised, numbness of the lower lip may occur.
   D. The use of the filling material is at the discretion of the surgeon. Discoloration of gum tissue from the filling material may occur.
   E. Injury or damage to tooth roots that are close by. You may later need root canal treatment, or even lose certain teeth.
   F. Fracture of the tooth. In most cases, the tooth will need to be pulled.

3. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgement to perform such additional procedures that are necessary and desirable to complete my surgery.

4. I understand that the apical surgery may not be successful and loss of the tooth may occur.

Initial:_____

5. **ANESTHESIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which 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 with it the rare risks of heart irregularities, heart attack, stroke, brain damage, and even death.

6. **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 your are sufficiently recovered to care for yourself. This may be up to 24 hours.
   B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
   C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING.**
   D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a **small sip of water**.

7. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed and I give my free and voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgement.

8. Women: your physician may prescribe antibiotics as part of your treatment. It has been the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed.

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

My signature below signifies that all my questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Witness' Signature Date

_____

Doctor's Signature Date

If surgery date different than date above, I have had the opportunity to again review, discuss, and change this informed consent.

_____

Patient's (or Legal Guardian's) Signature Date