APICOECTOMY CONSENT FORM

Consent for Surgical Endodontic Treatment
Patient Name: _____
Date of Birth: _____
Tooth/Area: _____
Date of Procedure: _____

1. **Explanation of the Procedure**
An apicoectomy is a minor surgical procedure that involves removing the tip (apex) of the tooth root and surrounding infected tissue, followed by sealing the root end. This is done when a standard root canal treatment has not fully resolved the issue or when re-treatment is not advisable.
2. **Risks and Complications**
I understand that as with any surgical procedure, there are potential risks and complications. These may include, but are not limited to:
- Post-operative pain, swelling, and/or bruising
- Bleeding or infection
- Damage to adjacent teeth or existing restorations
- Sinus involvement (for upper back teeth)
- Numbness or tingling of the lip, chin, tongue, or gums (usually temporary, rarely permanent)
- Incomplete healing or the need for further surgery or extraction

3. **Alternatives**
I understand that alternatives to this treatment include:
- Non-surgical root canal retreatment (if feasible)
- Tooth extraction
- No treatment, with the understanding that this may lead to worsening infection, discomfort, or bone loss

4. **Anesthesia**
I understand that local anesthesia will be used. I have been informed of the risks of anesthesia, including allergic reaction, nerve injury, and heart or breathing complications.
5. **Post-Operative Care**
I understand I will receive instructions on post-operative care. It is my responsibility to follow these instructions carefully to aid healing and reduce the risk of complications.
6. **No Guarantee**
I acknowledge that no guarantee, warranty, or assurance has been made to me as to the results of the procedure. I understand that the goal of treatment is to improve the condition, but that results may vary.
Patient Consent
I have read and fully understand this consent form. I have had the opportunity to ask questions and have them answered to my satisfaction. I authorize Dr. _____ and the dental team to perform an apicoectomy on the tooth(s) indicated.

Patient/Guardian Signature: _____ **Date:** _____
Doctor Signature: _____ **Date:** _____
Witness Signature (if needed): _____ **Date:** _____