

Consent for Endodontic Root End Resection (Apicoectomy)

I, _____, hereby authorize Dr. Meza/Dr. Lee/Dr. Patel to perform upon me the following procedures:

Removal of the end of the root(s) (root end resection) only and additionally the placement of a filling in the end(s) of the root(s) (root-end filling) on tooth number(s): _____.

I understand that Dr. Meza/Dr. Lee/Dr. Patel may discover conditions requiring different or additional procedures from that which were planned at the time of surgery. These would include sectioning more of the planned root, root amputation (sectioning the entire root), or sectioning other roots of the same tooth or adjacent teeth. I give my permission for these additional procedures that are advisable in the exercise of professional judgment. These additions and alterations in treatment at the time of surgery are rare and occur with very low probability.

Certain risks and complications associated with Endodontic Root Endo Resection include the following:

1. Delayed closure of incision site or closure of a sinus tract ("gum boil") of the alveolar mucosa and surrounding gingival.
2. Leaving a small piece of root in the jaw or sinus if it is not retrievable and attempt at removal would require more extensive surgery.
3. Post-operative bleeding, swelling, and discomfort that may last for a 3-5 days.
4. Bruising of mouth tissues or skin of face or lips.
5. Injury to adjacent teeth or soft tissues.
6. Temporary or permanent numbness of the lip, chin, gums, or tongue, (including possible loss of taste sensation).
7. Fractures of the jaw or thin bony plates of the jaw that may require additional treatment.
8. Perforations of the sinus floor that may require additional treatment and/or antibiotics and decongestants.
9. Restricted mouth opening for 7-10 days due trauma and post-operative infection.

Dental anesthetics used for these procedures, although considered safe, have certain associated risks and side effects that may include dizziness, and increased heart rate for brief period of time.

I have given a complete and accurate medical history, including all medicines and drug use. I also agree to fully comply with instructions given to me during the course of my treatment.

An informed accurate probability of the best and worst outcome of the procedure has been given to me, and I have been given the opportunity to have all questions answered to my satisfaction. I understand that the need for additional treatment to save my tooth may result in additional cost.

I hereby authorize Dr. Meza/Dr. Lee/Dr. Patel to perform the treatment(s) indicated above.

Patient's/Guardian's signature _____ Date _____

Treating Doctor's signature _____ Date _____

Biopsies are an important diagnostic tool for the diagnosis of lesions ranging from simple periapical lesions to malignancies. Planning prior to performing a biopsy is essential. The biopsy from the apicoectomy performed will be mailed to the Virginia Commonwealth University's dental oral pathology laboratory to be examined and diagnosed. We will collect a copy of your medical insure information as well as your contact information to attach with the biopsy sent. The biopsy fee is not included in the apicoectomy price. The Virginia Commonwealth University's dental oral pathology laboratory will bill your medical insurance, which may or may not result in an out-or-pocket responsibility for the patient.

I hereby authorize Dr. Meza/Dr. Lee/Dr. Patel to perform the biopsy indicated above to be sent to the Virginia Commonwealth University's dental oral pathology laboratory. By signing this is I understand there will an additional claim filed through my medical insure which may result in an additional fee, that I am responsible for.

Patient's name _____

Patient's/Guardian's signature _____ Date _____