



Consent for Endodontic Surgery

1. Purpose of Treatment You are required to sign this form prior to the initiation of surgical treatment. Your signature does not obligate you to proceed; it ensures you are fully informed about the proposed surgery, its risks, and your alternatives.

Depending on your specific clinical needs, endodontic surgery may involve one or more of the following procedures:

- Apicoectomy: Making a small incision in the gum tissue to remove infected tissue and the very tip of the tooth's root, followed by placing a small filling to seal the canal.
- Root Amputation: The surgical removal of one entire root of a multi-rooted tooth while preserving the remaining tooth structure.
- Intentional Replantation: Carefully extracting the tooth, treating the root(s) outside the mouth, and immediately reinserting the tooth back into its socket.
- Extraction: The complete removal of an unsalvageable tooth.
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While these surgical procedures have a high success rate and are primarily designed to save your natural tooth, results cannot be guaranteed.

2. Potential Risks and Complications I understand that endodontic surgery may involve the following risks, including but not limited to:

General Surgical Risks:

- Swelling, pain, bleeding, or bruising of the face and gums.
- Infection or inflammation of the surgical site.
- Complications resulting from the use of dental materials, medicines, anesthetics, and injections.
- Jaw muscle cramps, restricted jaw opening (trismus), or temporomandibular joint (TMJ) difficulty.
- Adverse reactions to medications or anesthetics (e.g., nausea, vomiting, allergic reactions).
- Delayed healing or treatment failure.
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Procedure-Specific Surgical Risks:

- Nerve Injury (Paresthesia): Numbness, tingling, or altered sensation in the lips, tongue, chin, face, gums, or teeth, which could last weeks, months, or in rare cases, become permanent (especially a risk for lower teeth).
- Sinus Involvement: Perforation or opening into the sinus cavity, which may require additional treatment or medication (especially a risk for upper teeth).
- Gum Recession & Aesthetics: Shrinkage or recession of the gum tissue after healing, which may expose the margins of crowns or the roots of the teeth, potentially altering your smile's appearance.
- Damage to Restorations: Loosening of or damage to the treated tooth, adjacent teeth, existing crowns, veneers, or bridges.
- Bone Healing: Incomplete healing of the bone, or the need for a bone graft and/or membrane to aid in tissue regeneration.
- Specific Procedure Risks: * Root Amputation: Weakening of the overall tooth structure, requiring a new or specialized crown to restore function.
 - Intentional Replantation: Fracture of the tooth during extraction, failure of the tooth to reattach or stabilize, or progressive root resorption over time.
 - Extraction: Bone loss over time and potential shifting of adjacent teeth if the space is not restored.

3. Other Potential Outcomes & Complications

- Tooth Fractures: Undetected cracks or root fractures may be discovered during the surgery. If a severe fracture is found, the surgery may be halted, and the tooth may require extraction.
- Unplanned Extraction: In some cases, despite our best surgical efforts, the tooth may be deemed unsalvageable during the procedure, or it may fail to heal properly afterward, ultimately requiring extraction.

4. Alternative Treatment Options I understand that I have the following alternatives to endodontic surgery, and each alternative carries its own risks (e.g., pain, infection, numbness, swelling, or loss of teeth):

- No Treatment: Risks may include increased pain, severe infection, swelling, bone loss, or a worsening condition.
- Primary Tooth Extraction: While choosing to immediately remove the tooth eliminates the need for advanced endodontic surgery, it may require replacement options such as a dental implant, bridge, or removable partial denture to restore function.

5. Post-Surgical Responsibilities

- I understand that I must strictly adhere to all given post-operative instructions to prevent infection and promote proper healing.
- I am responsible for returning to the office for a post-operative check-up and the removal of sutures (if non-dissolvable sutures are used).
- It is my responsibility to seek ongoing follow-up care with my general dentist as directed, which may include having a permanent restoration placed.

6. Medications and Safety Warnings

- Medications prescribed for discomfort or sedation may cause drowsiness, lack of coordination, or reduced awareness. I will avoid operating machinery or vehicles while using these medications.
- Antibiotics may reduce the effectiveness of birth control pills.
- Adverse or allergic reactions to medications may occur. I will report any adverse reactions to my treating doctor immediately.
- I will inform my treating doctor of any changes in my medical history prior to surgery.

7. Noncovered Services I understand that my recommended treatment plan may include diagnostic technologies (such as 3D CBCT imaging) or specialized clinical procedures (such as bone grafting) that are not covered by my dental insurance provider. I acknowledge that insurance coverage varies by plan, and I am financially responsible for the full cost of any noncovered services required or elected during my care.

8. Treatment Upgrades I understand that my treatment may involve the option to use advanced materials, techniques, or technologies that my insurance considers an "upgrade" to standard care. If I elect to proceed with an upgraded treatment, I understand that I am financially responsible for any additional costs associated with this upgrade that are not covered by my insurance plan.

9. Use of Images and Recordings I give my treating doctor permission to take photographs, voice recordings, or videos of my procedure for medical record-keeping and patient education purposes. All records will remain strictly confidential.

Patient Acknowledgement and Consent By signing below, I acknowledge that I have read and understand the information provided in this consent form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Patient Name (Print): _____
Patient/Guardian Signature: _____ Date: _____