AUBURN NY ORAL SURGERY

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CONSENT FOR TOOTH ROOT SURGERY

_____
Patient's Name Date

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

Your diagnosis is: _____

The procedure(s) necessary to treat the condition has been explained to me as:

- ☐ Removal of the end of the tooth root(s) (**Apicoectomy**)
- ☐ Placement of a filling at the end of the root(s) (**Retrograde filling**)
- ☐ Removal of an entire root of a tooth that has several roots (**Hemisection**)
- ☐ Pulling the tooth, completion of root canal fillings, apicoectomy and/or retrograde fillings and putting the tooth back into its socket (**Intentional Replantation**)
- ☐ Use of bone grafting material.
- ☐ Other:_____

Alternative treatment: methods include: _____

All surgeries have some risks. They include the following and others:

____A. Post-operative pain and swelling needing several days of at-home recovery.
____B. Prolonged or heavy bleeding that may need more treatment.
____C. Injury or damage to tooth roots that are close by. You may later need root canal treatment, or even lose certain teeth.
____D. You may get an infection after the procedure that may need more treatment.
____E. Scarring at the site of incisions inside the mouth, which rarely may also have cosmetic effects on the skin.
____F. The roots of the lower teeth might be very close to the nerve. After the surgery, there might be pain or a numb feeling in the chin, lip, cheek, gums, teeth or tongue. It is possible that you might lose your sense of taste. These things might last for weeks or months. It can be permanent, but this rarely happens.
____G. Fracture of the tooth. In most cases, the tooth will need to be pulled.

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____H. Leaving a small piece of root in place if doing a much larger surgery would be needed to remove it.
____I. Unusual or allergic responses to medicines used in the procedure.
____J. Discoloration (tattooing) of gum tissue from the retrograde filling material.
____K. Inability to gain total access to the root canals, possibly making it difficult to have a good result.
____L Going into the sinus. This could lead to bleeding from the nose and/or continued sinus problems that might need more treatment.
____M. The tip of a tool can possibly break off. If we are unable to take the tip out of the tooth, the result may not be as planned.

The anesthetic I have chosen for my surgery is:

- ☐ Local Anesthesia
- ☐ Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
- ☐ Oral Premedication with Local Anesthesia
- ☐ Intravenous Sedation with Local Anesthesia
- ☐ General Anesthesia with Local Anesthesia

____1. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, and allergic reactions. There might be swelling where an injection was given (phlebitis) that might cause discomfort and/or disability for a long time, and might need special care. You might have nausea and vomiting from the IV anesthesia, but this doesn't happen often. IV sedation and general anesthesia are serious medical procedures. They are safe, but the rare risks of heart problems, heart attack, stroke, brain damage or death are present.

____2. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:**

A. Because you will be very sleepy for some time after having an IV anesthetic medication, a responsible adult MUST come with you to drive you home and stay with you until you are recovered enough to take care of yourself. This recovery time may take up to 24 hours.

B. During this time 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 VERY IMPORTANT THAT YOU HAVE NOTHING TO EAT OR DRINK FOR **SIX (6) HOURS** BEFORE HAVINGYOUR ANESTHETIC. IF YOU DO NOT FOLLOW THIS RULE, IT **MAY BE LIFE-THREATENING!**

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D. However, it is important that you take any of your regular medicines (high blood pressure, antibiotics, etc.) or medicines given to you by us, **using only a small sip of water.**

____3. It is understood all encounters at Exclusive Oral Surgery LLC, including my consultation/surgery/follow-up/phone calls may be recorded for the purpose of training and/or documentation. This recording may become part of my permanent dental record or may be discarded at the sole discretion of the dental office.

If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

_____

Patient or Legal Guardian's Signature Date

_____

Doctor's Signature Date

_____

Witness' Signature Date