Informed Consent for Microsurgical Endodontic Treatment (Apical Surgery)

1. Treatment fees are due on the day treatment is started.

   Apical Surgery: _____

   Retrofill per canal: $300 x _____ = _____

   _____: $ _____ x _____ = _____

   Total Fee: _____

2. Complete and accurate disclosure of medical information about the patient is necessary for proper diagnosis and treatment and to minimize unnecessary complications related to surgical treatment.

3. The purpose of apical surgery is to retain a tooth that might otherwise require extraction (removal). Alternatives to apical surgery include: no treatment, root canal retreatment, or extraction.

4. In order to perform the apical surgery Dr. Bui will cut my gums, cut a hole into my bones, cut part of my root, retrofill if necessary, and place stitches. I understand that it may be necessary to place bone grafts and membranes to enhance healing of bone and surrounding tissue.

5. Risks and complications include but are not limited to the following:
   - Pain, swelling, bruising, bleeding, and spread of infection
   - Scaring of surrounding gums and tissue
   - Parasthesia of nerves (tingling, numbness or nerve pain) of surrounding tissue
   - Damage to restorations or roots of tooth or surrounding teeth
   - Overfilling of root canal materials outside the root canal and into the bone
   - Complications may require additional root canal therapy, extraction or follow-up of the tooth.

6. I acknowledge that there is no guarantee or warranty that the proposed treatment will be successful. There may be unforeseen preexisting conditions such as fracture of the roots or perforations that will render the tooth hopeless. There is a possibility of failure, relapse, additional treatment, worsening of present condition, or loss of tooth undergoing treatment and/or adjacent teeth despite the best of care.

7. I understand that it will be necessary for me to follow post operative instructions including:
   - Followup appointments for suture (stitch) removal and/or observation of healing
   - Adherence to medication schedule: antibiotics, pain relievers, mouth rinses, etc…
   - Avoid irritating the area (do not pull lips, cheeks and other surrounding tissues)
   - Avoid smoking

8. I authorize photos, radiographs or any other records of my care and treatment during or after its completion to be used for the advancement of dentistry and insurance purposes.

9. I have had the opportunity to ask questions and have received answers in words I understand concerning the treatment, inherent risks, and alternatives to treatment.

Date: _____

Patient Signature: _____
Or Parent/Guardian Signature if patient is under 18 years of age

Doctor Signature: _____

Assistant Signature: _____