PERIAPICAL SURGERY

Apicoectomy (tooth root surgery) with retrograde (root tip) filling

Apicoectomy (tooth root surgery) with retrograde (root tip) filling is a surgical procedure involving the apex of a root of a tooth or the membrane and adjacent bone structures around the tooth to treat a dead tooth. Apicoectomy is also called root resectioning. The root tip of a tooth is accessed in the bone and a small amount is shaved away. The diseased tissue is removed and a filling is placed to reseal the canal.

Patient’s Initials

_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of periapical surgery have been discussed with me and may include but are not limited to:

- Several days of swelling and discomfort, which may require staying at home before resuming normal activities.
- Bleeding, which can at times be heavy or prolonged and can occasionally require additional treatment.
- Postoperative infection, which may require additional treatment.
- Injury or damage to the adjacent teeth and tooth roots in the area of the apical surgery. Such damage can sometimes require root canal treatment, gum treatment, and, occasionally, tooth extraction.
- When the tooth is in the back part of the upper jaw, infection may extend into the sinus and require additional treatments, such as antibiotics and decongestants.
- The roots of the teeth in the back portion of the lower jaw are close to the nerves that provide the feeling to the lip, chin, and tongue. Occasionally these nerves can be damaged by the surgical procedure, which can lead to numbness. This is usually temporary, but it can be permanent.
- Possible alteration or loss of taste may occur that could possibly be permanent.
- Scar formation at the site of the incisions inside the mouth.
- Discoloration of the gum tissue in the area of surgery caused by the retrograde filling material (“tattoo” appearance formation).
- Sometimes a successful seal cannot be achieved because there are microscopic channels that are too small to be filled or the root is cracked. In such cases, tooth extraction is usually the only alternative.

_____ I understand and accept that complications, including the remote risk of death or serious disability, exist with any surgical procedure.

_____ I understand and accept the risks of blood transfusion(s) that may be necessary (if applicable).

_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The surgeon will do his/her best to minimize scarring but cannot control its ultimate appearance (if applicable).

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications (if applicable).

_____ I have informed the surgeon of all my known allergies.

_____ I have informed the surgeon of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including, but not limited to, estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation (if applicable).
____  Pre- and postoperative photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending surgeon (if applicable).

____  The surgeon has answered all of my questions regarding this procedure.

**Information for Female Patients:**

____  I have informed my surgeon about my possible use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate mechanical forms of birth control during the period of my treatment; and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ______________________, DDS/DMD/MD, with associates or assistants of his or her choice, to perform the procedure of __________________ on __________________ at ______________ on ____________________ at ______________ on the _____________________.

(right, left, level, body part)

I further authorize the surgeon(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time  Relationship to Patient

Print Patient or Legal Representative Name  Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Surgeon Signature/Date/Time

____ copy given to patient  _____ original placed in chart

initial  initial

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and The Joint Commission requirements, if applicable, and legal requirements of your individual state(s).