

Family Smile Center, LLC
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Frederick, MD 21704
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INFORMED CONSENT FOR Apical Surgery (apicoectomy)

Teeth area: _____

The Apical Surgery is being done with my approval.

I have been informed of alternative treatments which include: No Treatment, Retreatment of the Endodontics, and Extraction.

I understand that if this procedure is not done my condition may worsen resulting in complications including but not limited to:

1. Spread of Infection
2. Pain
3. Loss of the involved tooth
4. More loss of the jaw bone
5. Systemic involvement leading to complications of other parts of the body

Possible complications from the procedure discussed with me include, but are not limited to:

1. Infection
2. Swelling
3. Bruising
4. Parasthesia (loss or altered sensation)
5. Loss of the tooth
6. Devitalization of adjacent teeth
7. _____

I understand that the success of this procedure depend upon my cooperation and home care. If I do not follow the post operative instructions given, the success of this procedure may be reduced.

I understand the risks and consequences of this type of treatment.

All of my questions have been answered.

Signature of Patient

Date

Signature of Doctor

Witness