INFORMED CONSENT FOR SURGICAL PROCEDURE

Name: _____ Date: _____

1. I hereby request and authorize Dr. _____ to perform apicoectomy surgery on tooth # _____ on or about the _____ day of _____ for the purpose of attempting to improve the following conditions:

2. I also authorize Dr. _____ to perform any other procedure(s) deemed necessary of desirable in attempting to improve the condition(s) stated in paragraph 1, or improve on any unhealthy or unforeseen condition that may be encountered during the operation.

3. I consent to the administration of anesthesia as applied by or under the direction of Dr. _____ and to the use of such anesthetics and medication as deemed advisable in my case.

4. I have been advised that part of this surgery is (may be) performed through external incisions in the mucosa (gum), which could leave permanent scars the extent and location of which have been described and demonstrated to me.

5. I have been told that a filling material will be placed at the root tip and have been advised of the possible risks as well as alternative methods of treatment.

6. I understand that if Dr. _____ judges that my surgery should be postponed or canceled at any time or for any reason he/she may do so.

7. I hereby state that the information furnished to Dr. _____ during my comprehensive preoperative evaluation is correct.

8. Dr. _____ has fully explained all of the pertinent information regarding my proposed treatment, and I understand. Dr. _____ has fully explained, in terms clear to me, the effect and nature of the operation(s) to be performed, foreseeable risk involved and alternative methods of treatment.

9. I know that the practice of dentistry is not an exact science and therefore reputable dentist cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation I have herein authorized. In this connection, I have been advised that the goal of the operation is improvement in appearance and/or function, that there is a possibility that imperfections might ensue, and that the results might not live up to my expectations or the goals that have been established.

10. I have been given an opportunity to ask any questions I desire regarding the matters covered in the preceding paragraphs, and these questions have been answered to my satisfaction.

11. I assume all financial responsibilities for the proposed treatment.

Signature: _____ Date: _____

(Patient, or person authorized to give consent for the patient)

Witness: _____ Date: _____

(Not a member of the patient's family)