

**QUEENSBORO ORAL SURGERY ASSOCIATES, PLLC**  
*Oral and Maxillofacial Surgery & Implant Surgery*  
**Dr. Sanford M. Blecker/ Dr. Howard A. Ochs**



**INFORMED CONSENT FOR APICOECTOMY**

As a patient scheduled to have surgery involving my teeth, gums and surrounding bone, I understand that the purpose of the procedure is to treat and hopefully correct my diseased oral tissue. I realize that without treatment my present oral condition will probably worsen in time. Apicoectomy is a procedure designed to remove infection and/or cyst from the area surrounding the root of a tooth. There are many reasons that may cause an infection in this area. These may include fracture or perforation of the root, accessory canals, debris or bacteria harbored beyond the tip of the root and dead or dying nerve tissue in or beyond the tooth root. I am aware that in any surgical procedure there are inherent and potential risks. I understand that in this particular instance such risks include, but are not limited to:

1. Postoperative pain and swelling that may necessitate several days of home recuperation.
2. Heavy bleeding that may be prolonged.
3. Bruising of the face.
4. Injury to adjacent teeth, fillings, or restoration
5. Injury to surrounding gum and bone
6. Postoperative infection requiring additional treatment.
7. Stretching, cracking, and/or bruising of the corners of the mouth
8. Restricted mouth opening for several days or weeks.
9. Injury to the nerves in the area which can result in numbness, tingling, or altered sensation of the lip, chin, gums, cheek, teeth, and/or tongue of the operated side. This may [persist for days, weeks, months, or in rare cases, permanently.
10. Involvement of the sinus on the upper jaw, resulting in an opening into the mouth that may require further treatment.

I realize that I should not operate any vehicle, or hazardous device, nor consume alcoholic beverages while under the effects of medications given to me for use during or following this procedure.

If any unforeseen condition arises during the procedure calling for additional treatment from that now contemplated. I request and authorize whatever measures deemed advisable by my surgeon.

I realize that there is no guarantee that the proposed treatment will be curative and/or successful to my complete satisfaction. I am aware that individual patient differences result in the risk of failure, relapse, selective re-treatment, or worsening of the present condition despite the care provided. I understand that failing to following instructions concerning my care will increase the chances of a less than optimal result.

I certify that I read and write English and have read and fully understand this consent for surgery and anesthesia. I have asked the surgeon any question I have concerning this consent for and they have been answered to my satisfaction.

Consent is hereby given for apicoectomy of the following tooth/teeth:

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Witness