

*Mary Ann Choby DMD, MS*

Gentle, innovative care to restore and preserve your smile.

Mary Ann Choby, DMD, MS - 8133 LEESBURG PIKE #610,  
VIENNA, VA 22182

Office: (703) 448-8433 Fax: (703) 448-8464 Email: [info@drchoby.com](mailto:info@drchoby.com)

## **INFORMATIONAL INFORMED CONSENT: APICOECTOMIES AND APICAL SURGERY**

I UNDERSTAND that APICOECTOMIES include possible inherent risks such as, but not limited to the following:

1. Injury to the nerves: This would include injuries causing numbness of the lips, the tongue, tissues of the mouth and/or cheeks or face. This numbness which could occur may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
2. Bleeding, bruising, swelling: Bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.
3. Infection: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, infections may occur postoperatively. At times these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention should be received as soon as possible.
4. Sinus or Mandibular Canal Involvement: In some cases, the roots of the teeth that are going to be surgically treated lie closer to anatomic structures such as the Maxillary Sinuses or to the Mandibular Canal may be perforated, or the nerves emanating from the mental nerve foramen (opening in the jaw bone) may be traumatized during the surgical procedure involved with removing the apices of the infected teeth. Such events can cause the numbness described in #1 above.
5. Injury to adjacent teeth or adjacent roots: There is a possibility of injury to an adjacent tooth or roots of teeth during the procedure. If an adjacent tooth is inadvertently nicked or otherwise damaged during the surgical procedures, conventional endodontic treatment,

endodontic surgery, or extraction of the affected tooth may be required.

6. Bacterial endocarditis: Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and bacterial endocarditis (an infection of the heart) could occur. Pre-existing conditions causing valvular dysfunction are the most likely cause of this complication. It is my responsibility to inform the dentist of any heart problems known or suspected.

7. Failure: Even though the surgical procedure is properly performed, there exists the possibility that the attempt to preserve the tooth will fail due to the tooth and tissues not responding as they should, necessitating extraction of the tooth. Retrofills placed in the apicoectomy site may also leak or fail which can contribute to case failure.

8. Unusual reactions to medications given or prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

9. Retrofill induced discoloration: Some materials used to seal the apicoectomy site at the end of the root may cause temporary or permanent discoloration of the gingival tissues (gum tissue) at the surgical site.

10. It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.

**INFORMED CONSENT:**

I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment known as Apicoectomy and have received answers to my satisfaction. I have been given the option of seeking care from an oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Mary Ann Choby and her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

\_\_\_\_\_  
Patient's name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date