Consent form for Endodontic Surgery

Prince of Songkla Dental Hospital, Faculty of Dentistry

Name: ..... Age: ..... HN: .....

hereby decide to undergo Endodontic Surgery for tooth no. ....., total of ..... tooth/teeth.

Note (e.g., specify which tooth will be treated or any additional procedures that may be performed during surgery):

.....

.....

I acknowledge that I have been informed of the treatment plan and the following information:

Facts for Consideration

Endodontic Surgery is a treatment considered when the area around the root tip remains inflamed or infected after root canal treatment. This may be due to complex root canal anatomy or lesions that do not respond adequately to conventional root canal treatment.

The procedure involves lifting the gum tissue, removing the surrounding bone around the lesion, eliminating the inflamed tissue, and cutting off the root tip. A retrograde filling material will be placed at the root end. During the procedure, the root will be examined for cracks. If an irreparable crack is found, the tooth may need to be extracted. If the lesion is large and significant bone loss is present, bone grafting and membrane placement may also be necessary.

After the procedure, the surgical site will be sutured and may be covered with dressing material. Patients must return for follow-up and suture removal within 3–7 days.

Benefits of Treatment

Endodontic Surgery allows the natural tooth to be preserved for as long as possible, maintaining both esthetics and chewing function.

Risks of Treatment

Patients should monitor for any symptoms or abnormalities after surgery and strictly follow pre- and post-operative care instructions. The risks listed below may or may not occur:

- ☐ Pain or swelling after surgery, usually resolving within 5–7 days.
- ☐ Prolonged bleeding, bruising, or delayed wound healing.

☐ Despite infection control during surgery, oral bacteria may still cause infection. Seek dental care promptly if severe pain, swelling, fever, or fatigue occurs.

☐ Tooth mobility or gum recession, which may affect esthetics.

☐ There is a risk of damage to adjacent teeth or roots during bone removal or root-end resection, which may necessitate root canal treatment, surgical intervention, or extraction of the affected adjacent teeth.

☐ Numbness in nearby areas (e.g., lips, tongue, cheeks, face) due to anesthesia or the procedure. This is usually temporary but may last days, weeks, or months.

☐ Sinus perforation during upper back tooth surgery due to close proximity to the maxillary sinus. Antibiotics may be needed to prevent infection.

☐ Adverse drug reactions to anesthetics, antibiotics, or pain medications. All drugs should be used under dental or pharmaceutical supervision.

☐ Some retrograde filling materials may cause temporary or permanent discoloration of the surrounding gum tissue.

☐ Treatment failure can occur if the tooth or tissues do not respond, or if leakage of the root-end filling occurs. The tooth may ultimately require extraction.

Consequences of Not Receiving Treatment

If left untreated, the condition may continue to progress—with or without noticeable symptoms. Signs and symptoms may include pain, swelling, abscess or cyst formation, and bone loss around the tooth root. Over time, this may lead to the loss of the affected tooth and possibly adjacent teeth. In rare cases, the infection can spread systemically and become life-threatening.

Alternative Treatments

☐ Tooth extraction with prosthetic replacement (e.g., bridge, removable partial denture, or dental implant).

☐ Extraction without replacement may lead to shifting of adjacent teeth, bite changes, and potential periodontal disease.

Treatment Costs

Treatment costs are based on the most current fee schedule of the Dental Hospital, Faculty of Dentistry, Prince of Songkla University.

Patient's Decision

I have discussed the available treatment options and associated costs with my dentist. All my questions regarding the procedure, risks, benefits, and costs have been answered satisfactorily.

☐ I consent to the endodontic surgery and accept the risks and costs as described. I also consent to necessary dental radiographs throughout treatment.

☐ I do not consent to the endodontic surgery. I acknowledge that I have received the relevant information and understand the potential consequences of refusing treatment.

Signature: ..... Signature: .....

(.....) (.....)

Treating Dentist Patient / Authorized Representative

Relationship to the patient: .....

Signature: ..... Signature: .....

(.....) (.....)

Witness Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.