INFORMED CONSENT FORM FOR CORONECTOMY

Patient Name **ID**
Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE signing.
You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

My diagnosis is:

I hereby authorize Dr. and staff to perform the following planned treatment:
Alternative treatment methods include: □ No treatment,
A coronectomy or partial odontectomy is a procedure used to remove a tooth that has not yet broken through the surface of the gum, but has an increased chance of injuring the nerve that provides feeling to the lower lip and chin. The procedure is done by moving the gum away from the tooth and then cutting the crown (top) of the tooth off the root of the tooth. It is done in such a way so that the surrounding bone will "fill in" the space that was occupied by the crown of the tooth. The roots of the tooth are left in place so that the risk of injuring the nerve that give feeling to the lower lip and chin are reduced.

RISKS AND COMPLICATIONS OF CORONECTOMY include, but are not limited to:

1. There is still risk of injury to the nerve that supplies feeling to the teeth, gums, lower lip and chin and tongue where the procedure is done. In most cases the altered sensation is temporary but in rare cases can be permanent.
2. Risk of infection requiring additional treatment.
3. Risk of development of a cyst or other growth around the tooth root that might need more treatment.
4. Movement of the root is possible over a period of years. In most cases, if the root moves, it usually moves away from the nerve.
5. I should get x-rays over aperiod of several years to look at the area and determine how the bone is filling in the area.
6. In some cases, if the root fragment becomes loose during the surgery, you might have to take out the entire tooth.

CONSENT
I understand that most of the time you cannot tell this from x-rays taken before the procedure, so the decision can be made during the course of the procedure.
I understand that my doctor can't promise that everything will be perfect. I acknowledge that the above has been explained to my satisfaction, my questions have been answered, and I fully understand the risks involved with the proposed procedures. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc.

{X_____} **Date**
Patient's or Legal Guardian's Signature **Date**

{X_____}
Witness Signature