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CONSENT FOR CORONECTOMY

_____
Patient's Name *Date*

Please initial each paragraph after reading. If you have any questions, please ask Dr. Payne BEFORE initialing. You have the right to be given information about your planned surgery so that you can decide if you want to have the surgery. You will be asked to sign this form saying you understand what will be done, the risks that can happen, and the other kinds of treatment you could have.

Your diagnosis is_____

Your planned treatment is_____

Alternative treatment methods include_____

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 which 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 (X-rays will be required over a period of several years to determine how the bone has "filled-in" the area). The roots of the tooth are left in place so that the risk of injuring the nerve that gives feeling to the lower lip and chin are reduced.

Like all procedures, there are risks in performing the procedure, which include the following:

1. The risk of injury to the nerve that supplies feeling to the teeth, gums, lower lip, chin, and tongue in the area where the procedure is performed. In most cases, the altered sensation is temporary, but in rare cases, it can be permanent.
2. The risk of infection requiring additional treatment.
3. The risk of developing a cyst or other growth around the tooth root that might require more treatment.
4. The risk of the root moving over a period of years. In most cases, if the root moves, it usually moves away from the nerve.
5. The risk that the root fragment will become loose during surgery, possibly requiring the removal of the entire tooth. In most cases, the doctor cannot tell from the pre-procedure X-rays if this situation might occur; the decision to remove the tooth would have to be made during the course of the procedure.

CONSENT

I understand that my doctor cannot promise me a perfect procedure. I have read and understand the above and give my consent for surgery. If my doctor finds a different condition than expected and feels that a different or additional surgery is required, I consent to this surgery. I have given a complete and truthful medical history, including information regarding all medicines/drug use, pregnancy, etc. I certify that I speak, read, and write English and that all of my questions have been answered prior to signing this form.

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Dr. Payne *Date*

_____ _____
Signature of Witness *Date*