VISAGE SURGERY CENTER
Oral & Maxillofacial Surgery
Facial Cosmetic Surgery
FAISAL A. QUERESHY, MD, DDS, FACS, INC.
BOARD CERTIFIED • MEDICAL DIRECTOR

Consent for Apicoectomy

I hereby authorize **Faisal A. Quereshy, M.D., D.D.S.**, as a qualified Maxillofacial Surgeon, and such assistants as he may designate, to perform upon:

Please initial each paragraph after reading. If you have any questions, please ask Dr. Quereshy <u>BEFORE</u> initialing:

____1. An operation for the purpose of correcting a deformity, improving function and/or improving appearance, with respect to the following condition(s):

1. Failed root canal (endodontic) treatment

____2. The specific proposed operation(s), to which I agree to submit, is (are) as follows:

Apicoectomy

____3. I hereby swear that the operation(s) to correct the aforementioned condition(s) have been thoroughly explained to my satisfaction and, in addition, the specified risks involved have been explained and include, among others outlined, the following major complications:

Hemmorhage/Hematoma
Infection / loss of graft
3. Excessive swelling and/or bruising
4. Loss of teeth

____4. It has been explained to me that during the course of such operation(s), unforeseen conditions may be revealed which necessitates either an extension of the aforementioned operation(s), or modified procedure(s) other than those listed. I therefore authorize, and do request, that **Faisal A. Quereshy, M.D., D.D.S.,** his assistants or designees, perform such surgical procedure(s) that are necessary and/or desirable in the exercise of professional judgement. The authority granted in this item shall also include treatment of all conditions, which are now not known to **Faisal A. Quereshy, M.D., D.D.S.** but has become apparent at the time that the operation is commenced.

____5. I furthermore know and understand that the practice of Medicine and Surgery is not an exact science, and that, reputable physicians cannot guarantee any specific results. No guarantee(s) or assurance has been given to me by **Faisal A. Quereshy, M.D., D.D.S**., or his staff, as to the expectations or results that may be achieved. I have been completely honest with my surgeon regarding my motivation for undergoing cosmetic surgery realizing that a new appearance does not guarantee an improved life.

____6. I have discussed my past medical, health and social history, including drug and alcohol use, recognizing that withholding information may affect the planned goals of surgery. I agree to cooperate fully while under treatment, realizing that lack thereof can lead to an undesirable result, or may be life-threatening.

____7. If I use tobacco, I understand that I must **cease the use of all tobacco products at least two weeks prior to surgery**. Failure to do so may have serious negative effects on the success of my surgery.

I certify that I have had the opportunity to fully read this consent. I am likewise satisfied that any and all possible alternative methods of treatment have been thoroughly explained. My signature below indicates my agreement and understanding of my proposed treatment and I hereby give my willing consent to the surgery.

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Patient's (or Legal Guardian's) Signature **Date**

Doctor's Signature **Date**

Witness' Signature **Date**