



Tooth extraction and apicectomy

Information and consent for surgical procedures

Dental Aesthetics · Doctor medic Claudius-Horatius Moldovan · Simonstraße 3, 33106 Paderborn-Elsen · Version: 03/10/2026
English translation of the German form. In case of doubt, the German version applies.

Key points

This form prepares you for your conversation with the dentist. It does not replace it. Please read it at your leisure and note down your questions.

The procedure is carried out under **local anaesthetic**. You decide for yourself whether to consent. You can withdraw your consent at any time.

1. Patient and planned procedure

First name and surname: _____

Date of birth: _____ Legal representative (if any): _____

☐ **Tooth extraction**

☐ **Surgical tooth removal (osteotomy):** the tooth is exposed; for this the gum and, if necessary, a little bone are loosened.

☐ **Apicectomy (root-end resection):** the inflamed root tip is removed through a small opening in the jawbone and the root canal is sealed from there.

Tooth / teeth: _____

2. Possible risks and complications

- Swelling, bruising, wound pain and limited mouth opening in the first few days
- Secondary bleeding
- Wound infection, inflammation of the empty tooth socket, delayed healing
- Damage to a nerve in the lower jaw or to the tongue nerve: numbness or tingling of the lip, chin, tongue or teeth, altered taste – usually temporary, in rare cases permanent. The risk is higher with lower wisdom teeth.
- Fracture of the tooth, a root fragment remaining, very rarely fracture of the jaw
- Injury to neighbouring teeth, fillings, crowns or dentures
- Opening of the maxillary sinus in the side of the upper jaw (oro-antral communication); it must then be closed
- With apicectomy: renewed inflammation; the tooth may still be lost later despite the procedure
- From the local anaesthetic: intolerance, circulatory reaction, bruising, rarely nerve irritation; temporarily impaired fitness to drive

3. Alternatives

The dentist will discuss with you which alternatives exist in your case – for example keeping the tooth by root canal treatment, waiting, or no treatment – and what each would mean, and will note this under 6.

4. Before the procedure

- Please tell us about illnesses, allergies, intolerances and all medicines, especially blood-thinning medicines, and give us the name of your GP.
- **Do not stop prescribed medicines on your own initiative.** Whether anything is changed is decided by the prescribing doctor and the dentist.

5. After the procedure

Unless the dentist tells you otherwise:

- for 12 to 24 hours, preferably do not drive a car, ride a motorcycle or cycle yourself
- for 24 hours, no coffee, no black tea, no dairy products, no alcohol, no smoking
- for 48 hours, no sport and no heavy physical work
- cool the cheek from the outside
- do not take painkillers containing acetylsalicylic acid (ASA, for example aspirin), because they can increase bleeding. This does not apply to ASA that a doctor has prescribed for you on a long-term basis.

If you have heavy bleeding, increasing swelling, fever or lasting numbness, please call the practice: +49 5254 65333. Outside opening hours: dental emergency service 01805 / 98 67 00 (14 cents/min. from a German landline, max. 42 cents/min. from a mobile phone).

6. Consultation

Consultation on: _____ at (time): _____

Dentist providing the information: _____

Particular points in my case, alternatives discussed and my questions (to be completed by the dentist):

7. My decision

The dentist has spoken to me in person about the procedure, its risks, the alternatives and what to do before and afterwards. I was able to ask questions and had time to decide without pressure. I can withdraw my consent at any time without any formalities.

☐ I **consent** to the treatment named under 1 with local anaesthetic. This also covers medically necessary extensions that only become apparent during the procedure and cannot be postponed.

☐ I would **like more time** before I decide.

☐ I **decline** the treatment. I have been informed about possible disadvantages for my health.

Copy of this form: ☐ I have received one ☐ I do not want one

Place, date

Patient's signature

Place, date

Signature of the legal representative (if any)

Place, date

Dentist's signature

Information on data protection is given in the practice's "Patient information on data protection". This form becomes part of your patient record.