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CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned treatment so that you are able to and comfortable with making the decision to undergo the recommended procedure.

____ 1. My doctor has explained the following information about root canal therapy:

Root canal treatment is the procedure of cleaning diseased or infected tissue from inside the tooth followed by placement of a seal in the root canal. Using a local anesthetic, there is little or no discomfort during the procedure. Root canal therapy allows the tooth to remain in the mouth and contributes to sound, healthy and functional dentition for many years, if not a lifetime. The practice of endodontics also includes such procedures as bleaching, inducing closure of immature diseased root, treatment of traumatic injuries and the fabrication of posts and buildups under crowns. I have been made aware of my diagnosis and recommended treatment. Additionally, I have been given the option to see a specialist to complete the recommended endodontic therapy.

Diagnosis: _____

Planned treatment: _____

Alternative treatment methods include:

____ A. Extraction of the tooth. If the tooth is removed and not replaced, the empty space may create problems in tooth alignment due to shifting of adjacent teeth. This may result in periodontal (gum) disease and additional teeth could be lost as a consequence. The missing tooth may be replaced by an implant, fixed partial denture (bridge) or removable partial denture.

____ B. No treatment. This often results in persistent or recurrent pain and infection in the affected tooth.

_____ 2. I understand that there are risks associated with the proposed treatment including (but not limited to):

____ A. Perforation (extra openings) of the tooth or tooth root, possibly resulting in a non-restorable status

____ B. A split or fractured tooth, possibly resulting in a non-restorable status
____ C. Damage to existing restorations (fillings, crowns)
____ D. Separation of an instrument that cannot be removed from within the tooth or requires additonal treatment or referral to a specialist
____ E. Extrusion of materials or instruments beyond the end of the root, possibly requiring additional treatment or surgical intervention by a specialist
____ F. Pain, swelling, and/or infection
____ G. Complications or reactions resulting from the use of dental instruments, materials, drugs, sedation, medicines, analgesics, anesthetics and injections.
____ H. Numbness, pain, or altered sensation in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the close association of tooth roots to the nerves which can be injured or damaged. Usually the numbness or pain dissipates over time, but in some cases it may require additional treatment or may be permanent
____ I. Certain conditions may arise resulting in the necessary discontinuation of endodontic therapy and/or possible referral to a specialist, should this arise your dentist will make you aware and discuss the necessary recommendations
____ J. Other, generalized risks include: temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

I understand that after root canal treatment, it is recommended to have the tooth properly restored within a reasonably short time. Depending upon the situation, certain other post-treatment precautions or special instructions must be followed (such instructions will be given separately by the doctor or staff).

CONSENT

I understand that my doctor cannot promise perfect outcomes. I understand that there are risks and benefits to the recommended treatment and alternatives, including no treatment, exist. I have read and understand the above information and give my consent to surgery. I have given a complete and truthful medical history, including all conditions, prescribed, OTC and herbal/holistic medications, alternative drug use, pregnancy, etc. I certify that I have discussed all questions I have regarding the procedure with my doctor.

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

Doctor's Signature Date

Witness' Signature Date