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ENDODONTIC CONSENT AND INFORMATION FORM

Root Canal Therapy, Anesthetics and Medications

We would like to inform you of important information in regards to endodontic therapy and require your consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy. In order to determine whether you need treatment, digital radiographs (xrays) may be taken along with various clinical tests. In addition, limited field, CBCT (3-D digital xray) may be taken to assist the doctor in diagnosis and treatment planning.

The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

RISKS: Included (but not limited to) are; complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling or discoloration of the soft or hard tissue; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on rare occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth, referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing, and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC TREATMENT: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth or over extension of the filling material.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be intensified by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medications and drugs.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT: I, the undersigned, being the patient, parent or guardian consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that, ideally within 4-6 weeks of completion of my root canal treatment in this office, to help protect and promote healing I shall return to my general dentist for a permanent restoration of the tooth involved, such as a crown or permanent filling. I realize that a check up x-ray should be taken in 6 months by my own general dentist or by the treating endodontist.

Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Variations in anatomy and canal location may compromise success. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction. My questions have been answered to my satisfaction. I have carefully read the above statements and give my consent for the procedure.

The purpose of this document is not to alarm you. We have been advised not to begin treatment on anyone who has not read and signed this form.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____