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Consent for Endodontic Therapy

Please review the following consent. You will be required to sign it prior to the initiation of treatment. However, it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by
and any assistants with whom they work. I agree to the use of local anesthesia, depending upon the judgment of the dentist. I understand the dentist will consult with me prior to administering any sedation, and/or analgesia. Complications of root canal therapy and anesthesia may include: swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely permanent. I understand that it is my responsibility to report any symptoms to the dentist immediately.

I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require re-treatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore this tooth to function. These are separate procedures and ARE NOT included in the cost of the root canal therapy. During treatment, there is a possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth might not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risk involved in those choices might include but not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medications will be prescribed by the dentist. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use alcohol or operation of any vehicle or hazardous devices while taking such medications I further understand that certain medications may cause hives and intestinal problems and if any of the reactions occur, I am to call the dentist immediately. I understand that it is my responsibility to report any changes in the medical history to the dentist.

PLEASE DO NOT WRITE IN THE SPACE BELOW UNTIL YOU HAVE TALKED TO THE DOCTOR.

Notes: _____

_____

Procedure Date Doctor Assistant

If there is anything you do not understand about the endodontic procedure, or any statements in this form, or if you still have questions after reading this form and talking to the doctor, please write you question below. If you have no questions, please write "NONE"

_____

Signature _____

All signatures must be by a parent or legal guardian if patient is under the age of 18