

CONSENT TO EXAMINE AND TREAT

You have been referred for endodontic (root canal) evaluation and, if necessary, treatment. The consultation consists of history taking, clinical examination, appropriate tests, and diagnostic radiographs (X-rays). A diagnosis and treatment recommendation will be presented.

Root canal therapy is completed in one or more separate appointments. The objectives of this treatment are: to relieve pain and infection, if present; remove the diseased pulp tissue; and clean, disinfect and fill the root canals. Radiographs will be required during the treatment. Local anesthetics are usually required. And antibiotics and analgesics may also be needed.

The following possible risks may occur at any time during treatment.

RISKS: Complications resulting from, but not limited to, the use of dental instruments, drugs, sedation, medicines, anesthetics, and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gum, cheeks and teeth, which is transient but on occasions may be permanent reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the 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 the canals and cracked teeth. During treatment complications (such as; blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal [gum] disease, splits or fractures of teeth) may be discovered which make treatment impossible or which may require dental surgery.

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

ACKNOWLEDGMENT AND CONSENT: I, the undersigned, being the patient or guardian of a minor patient, acknowledge that I have read this form and consent to the performance of the described procedures. I reserve the right to refuse further treatment at any time and accept the consequences of that decision. I also understand that I may need to return to my general dentist for permanent restoration of the tooth.

I understand that root canal treatment is an attempt to save the tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed and additional treatment such a surgery or extraction may be necessary.

Date: _____ Signature: _____ Witness: _____

If minor, parent or guardian