



ENDODONTIC CONSENT AND INFORMATION SHEET

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which might otherwise need to be removed. This can be accomplished by conventional root canal therapy or when needed, endodontic surgery. The following discusses possible risks that might occur from endodontic 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, sensitivity, bleeding, pain, infection, numbness or tingling in the face and gums. On infrequent occasions reactions to the injection, changes in occlusion (biting), jaw muscle pain (cramps & spasms) losing teeth, referred pain to the ear(s), neck or head pain, nausea or delayed healing may occur.

RISK MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments separating within the root canals, perforations (extra opening) of the crown or tooth, damages to bridges, existing fillings, crowns, or porcelain veneers, loss of tooth structure in gaining access to canals and cracked teeth. During the procedure, complications may be discovered which make treatment impossible, or which may require dental surgery. The complications may include blocked canals due to filling or prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease) or fractures of the teeth.

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

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms or tooth extraction. All of the choices carry risk of their own.

INSURANCE: Our professional services are rendered and charged to you and not your insurance company. However, if insurance information is provided prior to your treatment and verification is obtained, as a courtesy, we will accept assignment of benefits from your insurance carrier. It is the patient's responsibility to pay the deductible and the co-payment (patient portion) of the incurred fees. All fees incurred via legal attempts to collect any patient portion will be financial responsibilities of the patient or guardian.

CONSENT: I, the undersigned, being the patient (parent or guardian) consent to the performing of the agreed upon procedure as it is deemed necessary or advisable by the doctor. I also understand that upon completion of the root canal procedure, I will return to my general dentist for permanent restoration of the tooth. I understand that the root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it is not guaranteed. Occasionally a tooth which has had prior root canal may require additional treatment, surgery or extraction.

I have read and acknowledged the content of this information and consent to proceed with treatment.

Patient (Parent or Guardian)

Today's Date