



CONSENT FOR TREATMENT

Patient Name: _____

DOB: _____

REASONS FOR TREATMENT: Endodontic (root canal) therapy is accomplished in an effort to save a tooth which otherwise would require extraction. Treatment is done by standard root canal therapy, or when necessary, endodontic surgery.

RISKS SPECIFIC TO ENDODONTIC THERAPY: Those risks include the possibility of instruments broken within the root canals, perforations, damage to crowns or the root of the tooth, damage to existing bridges, fillings or crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require endodontic surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, splints or fractures of the teeth.

OTHER RISKS OF TREATMENT: Included (but not limited to) are complications resulting from the use of instruments, drugs, sedation, medicines, analgesics (painkillers), anesthetics and injections. These complications include: swelling, 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 (the bite), jaw muscle cramps and spasms, temporomandibular (TMJ) difficulty, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any motor vehicle or hazardous device until recovered from their effects. **IN THE EVENT YOU NEGLECT TO INFORM US OF NARCOTICS YOU ARE TAKING BY ANOTHER DOCTOR SERIOUS ACTION MAY BE TAKEN.**

I, the undersigned, being the patient (parent or guardian of a minor patient) consent to the evaluation and or any procedures deemed advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I **NEED TO RETURN TO MY REFERRING and/or REGULAR DENTIST** for a permanent restoration of the tooth involved. I understand that 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 cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require additional treatment, such as surgery or even extraction.

PATIENT or PARENT/GUARDIAN SIGNATURE

DATE