Open and Affordable Dental and Braces ®

BP:_____/_____HR:_____BPM

CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Patient's Name: _____

My diagnosis is: ☐ Symptomatic Irreversible Pulpitis ☐ Necrosis with apical abscess ☐ Caries to pulp ☐ Other_____

My planned treatment is: ☐ Root Canal Treatment ☐ Other _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned treatment so that you can decide whether to have a procedure or not after knowing the risks and benefits.

_____ 1. My doctor has explained the following information about root canal therapy:

- Root canal treatment is the procedure of cleaning diseased or infected tissue from inside the tooth followed by placement of a seal in the root canal. Using a local anesthetic, there is little or no discomfort during the procedure. Root canal therapy allows the tooth to remain in the mouth and contributes to sound, healthy and functional dentition for many years, if not a lifetime. The practice of endodontics also includes such procedures as bleaching, inducing closure of immature diseased root, treatment of traumatic injuries and the fabrication of posts and buildups under crowns._____

_____ 2. My doctor has explained that there are alternatives to root canal treatment that include:

- Extraction of the tooth. If the tooth is removed and not replaced, the empty space will create problems in tooth alignment because of shifting of adjacent teeth. This may result in periodontal (gum) disease and more teeth could be lost as a consequence. The missing tooth may be replaced by a bridge or partial denture, but the cost of this treatment is more expensive than root canal treatment and involves dental work on adjacent teeth.
- Implant placement.
- No treatment. This often results in persistent or recurrent pain and infection in the affected tooth

_____ 3. I understand that there are risks associated with the proposed treatment including:

- Possibility of perforation of the tooth or tooth root
- Damage to existing restorations (fillings)
- A split or fractured tooth
- Separation of a portion of an instrument that cannot be removed from within the tooth
- Pain
- Swelling
- Infection
- Injury to the nerve that gives feeling to the face that could result in pain or a numb feeling in my chin, lip, cheek, gums, teeth or tongue. It is also possible to lose my sense of taste. This might last for weeks or months. It can be permanent, but this rarely happens.
- Other: _____

I have not been given any guarantee or warranty of success for this treatment, and understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same, better or worse after treatment and that ongoing care may be necessary.

I have provided a complete and accurate statement of my medical and social history. I understand that after root canal treatment, it is usually wise to have the tooth properly restored within a reasonably short time. Depending upon the situation, certain other post-treatment precautions or special instructions must be followed (such instructions will be given separately by the doctor or staff). I understand that my dentist is not a specialist in endodontics, and I can choose to be referred to an endodontic specialist.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____