Endodontic Treatment Consent

Nature Of Endodontic Treatment

Root canal treatment has been recommended for me on the following tooth (teeth):

_____

Root canal treatment (also called endodontic treatment) requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root(s). It is done by first making an opening through the chewing surface of the tooth to gain access to the tooth's pulp. The contents of the canals are removed and the canals cleaned and shaped. The canals are then filled and sealed with an inert, rubbery material called gutta percha. Following root canal treatment, the tooth will need a final restoration, usually a crown, to return it to proper function. The final restoration is not part of this discussion and consent.

The intended benefit of root canal treatment is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed. Root canal treatment also retains the tooth root in my mouth, permitting the tooth to be restored to proper function.

Alternatives to Endodontic Treatment

Depending on my diagnosis, there may or may not be alternatives to root canal treatment that involve other types of dental care. I understand the three most common alternatives to root canal treatment are:

1. Extraction. I may choose to have tooth #_____removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
2. Waiting for more definitive symptoms to develop.
3. No treatment. I may choose not to have any treatment performed at all. If I choose no treatment, my condition may worsen and I may risk serious personal injury, including severe pain, localized infection, loss of this tooth and possibly other teeth, severe swelling, and/or severe infection that may be potentially fatal. I understand if I choose this alternative, the doctor may choose to dismiss me from the practice due to noncompliance with recommended dental treatment.

I have had an opportunity to ask questions about these alternatives.

Risks Of Endodontic Treatment

I have been informed and fully understand that there are certain inherent and potential risks associated with root canal treatment.

I understand that the following may be inherent or potential risks for the treatment I will receive: swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments—perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills or may cause an antibiotic associated colitis.

It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

I understand that root canal instruments sometimes separate (break) inside the canal. This is more likely when canals are curved and/or narrowed. If the separated fragment cannot be retrieved, it may need to be sealed inside the root canal. It may also be necessary to have oral surgery performed on the tooth root (apicoectomy) to address the problem. I understand that a separated instrument often decreases the likelihood of clinical success.

There is also a risk of swallowing or aspirating an instrument or other foreign body.

I understand that many factors contribute to the success of root canal treatment, and not all factors can be determined in advance, if ever. Some of the factors are: my resistance to infection; the specific bacteria causing the infection; the size, shape, and location of the canals; the force with which I bite; etc. I understand that my case may be more difficult if my tooth has blocked canals, curved canals, or very narrow canals.

I understand that root canal treatment may not relieve my symptoms, that treatment can fail during or after completion of treatment, and that it may fail for unexplainable reasons. If treatment fails, other procedures (including root canal retreatment and/or oral surgery) may be necessary to attempt to retain the tooth, or it may have to be extracted.

I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that once root canal treatment is completed, the tooth will need a final restoration, usually a crown, to return it to proper function. The final restoration is not part

of this discussion and consent. I understand I must promptly begin this next step in treatment. If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth.

Patient Signature

By signing this document, I am freely giving my consent to allow and authorize

Dr. _____

and/or their associates to render the root canal treatment discussed.

I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

Patient: _____ Signature: _____ Date_____

Witness: _____ Signature: _____ Date: _____