GLACIER VALLEY
ENDODONTICS

Endodontic Consent and Information

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to removed. This is accomplished by the conventional root canal therapy (through the top of the tooth) or when needed, endodontic surgery (performed through the gum). The following discusses possible risks and alternative treatment choices.

General Risks

Included, but not limited to, are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain medication), anesthetics, canal disinfectant materials (including sodium hypochlorite, chlorhexidine) and injections. These complications may include: swelling, bruising, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, face and teeth (which is usually transient, but on infrequent occasions may be permanent), reactions to injections, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

Other risks include the possibility of instruments broken within the root canals; overextension of the filling material beyond the end of the root; perforations (extra opening) 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 canals; and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), and splits or fractures of the teeth.

If the tooth is covered by a crown, I understand that a hole must be drilled through the crown to access the root canal system. I understand that the crown or adjacent teeth/crowns may be damaged in the process, requiring a new crown or repair.

Medications & Other Treatment Choices

Some prescribed medications and drugs may cause drowsiness and lack of awareness and co-ordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Other treatment choices include no treatment, waiting for more definitive development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, tooth loss, and spread of infection to other areas of the body.

Signature_____

Consent

I, the undersigned, being the patient (parent or guardian of minor patient) consent to performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration of the tooth involved, such as a crown or filling.

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 which has had root canal therapy may require retreatment, surgery, or even extraction.

In some instances the doctor may determine and recommend a permanent restoration be placed after root canal treatment has been completed. I understand that there is a separate fee for this procedure in addition to the fee for root canal treatment. I have also been given the opportunity to discuss the different restoration materials advantages and disadvantages with the doctor and have been given a choice between the different materials to be placed. Fee for Treatment_____
Initials_____

I hereby state that I have read and understand this consent. I have been given the opportunity to ask questions and they have been answered for me. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment. I am medically and physically competent to understand this form and have not taken any mood or mind-altering drugs during the twelve hours prior to signing this document.

$_____. Corrections:_____.
Fee for Treatment

_____.
Tooth/Teeth

Patient Signature:_____ Date:_____.

Witness Signature:_____ Date:_____.