NORTHBRIDGE SMILES

Endodontic Treatment Consent

Patient_____ Date_____

This is my consent for Dr._____ and/or any staff member working with him/her to perform the following treatment/procedure/surgery _____as previously explained to me.

I am being provided this information and consent form so I may better understand the recommended treatment recommended. I want to be provided with enough information, in a way I can understand, to make a well-informed and confident decision regarding my proposed treatment. I undusted that I may ask any questions I wish and that it is better to ask them before treatment begins that to wonder about it after treatment has started. Nature of Endodontic Treatment

Root canal treatment has been recommended for me in the following tooth (teeth):_____.

Alternatives to Endodontic Treatment

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

Extraction: I may choose to have the tooth #_____removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.

No Treatment: I may choose to not 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 have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about including:

Risk of Endodontic Treatment:

I understand that it is possible for an infection to occur or an existing infection worsen in the tooth being treated and/or in the area around the tooth, and that I may need antibiotics and/or other procedures to treat the infection. 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 an 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. I understand that other risks include: perforation of the tooth or tooth root by an instrument; injury to soft tissues adjacent to the tooth; sinus perforation; and nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

Initial _____

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 infection; to size, shape and location of the canals; the force with which I bite. I understand that my case may be more difficult if my tooth has blocked canals, curved canals, or very narrow canals.

Initial_____

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 treatment and/oral surgery) may be necessary to attempt to retain the tooth, or it may have to be extracted.

Initial _____

I understand that once root canal treatment is completed, I must promptly return to begin the next step in treatment. If I fail to return to have the tooth restored, I risk failure of the root canal treatment, decay, infection, and tooth fracture and loss of tooth.

Initial _____

Patient signature: _____ Date: _____

Doctor signature: _____ Date: _____