

INFORMED CONSENT FOR ENDODONTIC TREATMENT

- 1) I understand that the goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high degree of clinical success, it is a biological procedure and success cannot be guaranteed.
- 2) I have been informed of possible treatment alternatives including; extraction and no treatment at all.
- 3) I understand that there are certain inherent risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive.
 - a) Swelling; sensitivity; bleeding; pain; infection;
 - b) Numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth which is transient but on infrequent occasions may be permanent;
 - c) Reactions to injections;
 - d) Changes in occlusion (biting), jaw muscle cramps and spasm; temporomandibular joint difficulty
 - e) Loosening of teeth, crown or bridges; or damage to existing restorations which may necessitate replacement of the restoration;
 - f) Referred pain to ear, neck and head; delayed healing; sinus perforation;
 - g) Treatment failure; complications resulting from the use of dental instruments (broken instrument, perforation of tooth, root or sinus), medications, anesthetics and injections, discoloration of the face;
 - h) Reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effects of birth control pills
 - i) Further treatment may be necessary
- 4) I understand that this procedure will not prevent future tooth decay, tooth fracture or gum disease and occasionally a tooth that has had root canal treatment may require retreatment, endodontic surgery or extraction
- 5) I understand that once root canal treatment is completed, I must promptly return to my referring dentist to have the tooth restored. If I fail to have the tooth properly restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth.
- 6) I have been given the opportunity to discuss this form and question the doctor concerning the nature of treatment, the inherent risks of the treatment and the alternatives to this treatment
- 7) This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment

Patient and/or Guardian Signature

Date

Printed Name

Tooth #