



Name _____

Chart # _____

INFORMED CONSENT TO ENDODONTIC THERAPY

I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction and that as a specialty practice, the office performs endodontic treatment, associated surgery and other dental procedures. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy may require re-treatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration consisting of a crown, build-up, and /or post and core will be necessary to restore the tooth to function by your general dentist. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. In addition there are times when a surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and spread of infection.

At times, medication will be prescribed by the endodontist. I understand that medication for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

In some instances, the endodontist will prescribe antibiotics to treat infection. In the event I am prescribed antibiotics and I am female, my current contraceptive method may become ineffective and to decrease the risk of becoming pregnant, it is essential that I use an additional method of contraception.

I have read this information and this is my consent for the endodontic procedures indicated and any other procedures deemed necessary or advisable in correlation to the planned endodontic therapy performed by Dr. Jill Peterson and by any assistants with whom she works. I agree to the use of local anesthesia, depending upon the judgment of the endodontist. I understand the endodontist will consult with me before administering any oral pre-medication for anxiety.

Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, chin, gum or tongue, which rarely is protracted and even more rarely permanent. I understand that it is my responsibility to report any symptoms or post operative complications to the endodontist immediately.

If there is anything that you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form and talking to the doctor, please write your questions in the space below. If you do not have questions, please write "NONE".

NOTES:

Procedure _____ Date _____ Dr. _____ Assistant _____

Patient Signature (parent or guardian if minor)

