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Endodontic Associates

INFORMATION AND CONSENT

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. The following are possible risks that may occur with endodontic treatment.

GENERAL RISKS OF DENTAL CARE:

Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as: antibiotics, analgesics (pain killers), and local anesthetic injections. These complications may include swelling; sensitivity; bleeding; pain; infection; **numbness and tingling sensation in the lip; tongue; chin; gums; cheeks; and teeth; which is usually temporary but may be permanent;** reaction to injections; changes in biting; jaw muscle cramps and spasms; joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY:

The risks include the possibility of instruments broken within the root canals: perforations (extra openings) of the crown or root; 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 may include: blocked canals due to filling prior to treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS:

Some prescribed medications and drugs may cause drowsiness, lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). Women who are taking birth control pills, and are given a prescription for an antibiotic are strongly advised to use additional means of birth control during the entire monthly cycle. If you are using any prescribed or over the counter drugs, please inform the doctor prior to any treatment.

OTHER TREATMENT CHOICES:

These include no treatment, waiting for more definite symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and spread of infection to other areas.

CONSENT:

I (parent or guardian if minor patient) consent to performing of the procedures necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy, I shall return to my family dentist for a final restoration of the tooth treated, (crown, cap, only 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, corrective surgery or extraction.**

If you have any questions regarding the procedures, medications, or costs involved, please ask prior to the start of treatment.

I hereby state that I have read and understood this consent.

HIPAA

I acknowledge that this office's notice of privacy practices is available to me and is posted in the lobby.

INSURANCE / FINANCIAL

I authorize the release of any information relating to this claim and hereby direct benefits payable to the attending dentist. My co-payment is due at initiation of treatment. Any balance not paid by insurance is my responsibility.

Patient Signature

Date