West GA Endodontics

NAME_____

CONSENT TO ENDODONTIC THERAPY

Please review the following consent. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists, and any assistant he/she may require. I agree to the use of local anesthesia, depending upon the judgment of the endodontist. I understand the endodontist will consult with me prior to administering any sedation. **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, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.**

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 only endodontic therapy and associated surgery. 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 retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth to function; this will be performed by my dentist. During treatment there is the possibility of: instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my 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 these choices might include, but are not limited to: pain, infection, swelling, loss of the tooth, and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications 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/or 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.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherit risks of the treatment, and the alternative to this treatment.

PLEASE DO NOT WRITE IN THE SPACE BELOW IF YOU HAVE ANY QUESTIONS FOR DR. GREEN

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, please ask the doctor before treatment is started.

_____ _____ _____ _____

Date Procedure Signature Doctor

*Signature must be by a parent or guardian if the patient is under the age of 18.