ENDODONTIC CONSENT AND INFORMATION FORM

Root Canal Therapy, Anesthetics, and Medications

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

RISKS: The risks are included (but not limited to) complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness; and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on rare occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of the teeth, referred pain to ear, neck, and head; nausea; vomiting; allergic reactions; delayed healing; and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC SURGERY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; 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 make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be intensified with the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medications and drugs.

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

CONSENT: I, the undersigned, being the patient, parent, or guardian consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay, or silver filling. I realize that a check up x-ray should be taken in 6 months by my own general dentist or by the treating endodontist.

Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Variations in anatomy and canal location may compromise success. Occasionally, a tooth which has had root canal therapy and canal location may require treatment, surgery, or even extraction. My questions have been answered to my satisfaction. I have carefully read the above statements and give my consent for the procedure. Furthermore, I give Dr. Michael Marcello my permission to voice record, tape digitally, videotape, and/or take 35mm and/or digital photos of my procedure for purposes of completing my medical record and/or for patient education. The purpose of this document is not to alarm you. We have been advised not to begin treatment on anyone who has not read and signed this form.

PATIENT (PRINT NAME) _____

SIGNATURE _____ **DATE** _____
(PATIENT OR GUARDIAN)