NORTH WOODSTOCK DENTISTRY

DENTAL PROGRAMS
CONSENT FOR ENDODONTIC (ROOT CANAL) SERVICES

Patient Name_____ Date: _____

I hereby authorize Dr. _____ to perform an endodontic (root canal) procedure on tooth (teeth) #_____, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Root canal therapy is indicated when the pulp chamber of a tooth is contaminated by bacteria causing the canals to become infected. The procedure is accomplished when the dentist creates a small opening in the biting surface of the tooth that will allow it to be disinfected and then sealed with an inert rubber-like substance. The sealing of the canals prevents subsequent passage of bacteria into or out of the tooth.

I have been informed that the risks to my health if this procedure is not performed may include, but are not limited to: increased pain, swelling, loss of the tooth (teeth), loss of other teeth nearby, loss of the supporting bone, spreading infection, cyst formation, and/or deterioration of general health due to systemic infection.

I have been informed of possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

- A failure to completely eliminate the infection requiring retreatment, root surgery or removal of the tooth at a later date;
- Post-operative pain, swelling, bruising, and/or limited jaw opening that may persist for several days;
- Separation (breakage) of an instrument within the canal during treatment. Broken instrument tips are typically allowed to remain in the canal, and only rarely are they the cause of subsequent problems. If removal is indicated the patient may be referred to an endodontic specialist.
- Perforation of the root from within the canal can occur requiring additional treatment by a specialist. Such complications will occasionally result in the loss of the tooth. Any such referral would be at an additional cost.
- Damage to nerves supplying the teeth resulting in temporary or, in rare instances, permanent numbness or tingling of the lip, chin, or other areas of the jaws or face:
- Inability to adequately clean the canal(s) due to unforeseen calcified obstructions or severely bent roots. Under certain circumstances the patient may be referred to a specialist for successful completion of the procedure at an additional cost and there is a chance that the loss of the tooth may occur.
- A fracture of the treated tooth, occurring during or after endodontic treatment. Treated teeth sometimes break due to the tooth's loss of strength resulting from the procedure. In most cases a crown is recommended after treatment to reduce the chance of such an occurrence.

I have been informed of the approximate cost of the procedure, and I understand that I am responsible for any outstanding balance that my insurance does not cover. Once treatment has begun, it is essential that it be completed in a timely manner. Root canal treatment will require from 1-3 appointments. Also, I understand that successful treatment does not prevent future decay or fracture of the treated tooth.

I understand the recommended treatment, the risks of such treatment, alternative treatments should any exist, and the consequences of doing nothing.

Patient's Signature_____ Date_____

Parent or Legal Guardian Signature_____ Date_____

Witness or Interpreter_____ Date_____