PARKWOOD DENTAL

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Endodontic Informed Consent

Root canal therapy (endodontic treatment) is a procedure that retains a tooth which would otherwise require extraction. Although root canal therapy has a high success rate, results cannot be guaranteed. Occasionally, a tooth that has undergone a root canal may require re-treatment, surgery, or even extraction. Following treatment, the tooth will discolor and become brittle and subject to fracture- therefore, a crown (sometimes including post and core) is necessary to restore the tooth. During endodontic treatment there is the possibility of instrument fracture within root canals, perforations, or tooth fracture depending on the extent of infection. There are times when a minor surgical procedure may be indicated, or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment or tooth extraction. Risks involved in treatment might include, but are not limited to:

- Pain, infection, swelling, loss of teeth, and spread of infection to other areas.
- Reaction to medications/anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, or other areas
- Potential for re-treatment of root canal or possible surgical procedure
- Post treatment infection
- Root fracture/crown fracture
- Recurrent decay
- Sensitivity/pain

It is imperative that you follow the doctor's recommendations and treat the infection as early as possible to avoid these potential issues. Depending on the presentation of pain & infection, the doctor will prescribe medication. Medications prescribed for discomfort and/or sedation may cause downiness, which can be intensified by the use of alcohol or drugs. You should not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives, or intestinal discomfort. If any of these problems occur, call immediately. It is the patient's responsibility to report any changes in his/her medical history to the doctor.

PATIENT CONSENT: I, _____(print name) have been fully informed of the treatment to be performed. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self care. I understand the potential outcome of not undergoing treatment. I am aware that additional treatment may be necessary. I have had an opportunity to ask my doctor any questions, all of which have been answered to my satisfaction.

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

_____ _____

Witness Signature Date