Endodontics

Informed Consent for Endodontic Treatment and/or Surgery

1. I _____ (Print Name) hereby authorize Dr. _____ and any other or employees of Endodontics, LLC and such assistants as may be selected by any of them to treat the condition(s) described below:

   - ☐ Pulpal Inflammation / Degeneration
   - ☐ Infection of Previous Endo. Treatment
   - ☐ Tooth Discoloration
   - ☐ Other:_____
   - ☐ Periapical Disease
   - ☐ Orofacial Pain
   - ☐ Cracked Tooth / Root Fracture

2. The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be:

   - ☐ Root Canal Treatment
   - ☐ Retreatment (Revision)
   - ☐ Bleaching
   - ☐ Endodontic Surgery
   - ☐ Apexification (Root End Formation)
   - ☐ Other: _____

3. I have been informed of the prognosis and benefits of this procedure.

4. I have been informed of possible alternative methods of treatment including no treatment at all.

5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that these risks for the treatment I will receive include, but are not limited to:

   swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; change in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty; loosening and/or breakage of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; perforation of the tooth; sinus perforation; treatment failure; loss of the tooth; additional root canal treatment of another tooth; resorption; ankylosis; complications resulting from the use of dental instruments (broken instruments, perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills.

6. It has been explained to me and I understand that optimal results are not guaranteed or warranted and cannot be guaranteed or warranted.

7. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternative to this treatment.

8. I have read this consent form and voluntarily consent to the performance of the above procedure(s) upon me.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Witness's Signature _____ Date _____