RED BANK ENDODONTICS

INFORMED CONSENT FOR ROOT CANAL TREATMENT

Patient's Name Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR DURING YOUR APPOINTMENT.

_____ Only the RCT is to be performed at this office. The permanent outside restoration (filling, onlay, crown, etc.) will be done by my regular dentist.

_____ I acknowledge full responsibility for the payment of such services and agree to pay for them in full AT or BEFORE COMPLETION of treatment.

_____ Success rate - Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Root canal treatment (RCT) can fail but is usually about 95% successful after proper final restoration by your general dentist (e.g., crown, inlay, etc.). Occasionally, a tooth which has Root Canal therapy may require retreatment, surgery, or even extraction.

_____ I have the choice of EXTRACTION, doing nothing (understanding infection can occur, if there is no treatment at all), or retreatment if RCT had been done previously.

_____ The tooth/teeth may still need surgery or extraction after the root canal treatment.

_____ Loss of feeling (i.e., numb ness) or tingling in the lip, tongue, chin, gums, cheeks, and teeth, may temporarily occur, (rarely may be permanent)

_____ Canals can be calcified (blocked) and may require root end surgery, if pain persists or root pathology (e.g., infection) is present or develops.

_____ Complications resulting from use of dental instruments may result in a perforation (accidental exit out the side of the root, while attempting to find canals) and instruments breaking in the canal(s) perhaps making root end surgery necessary which can affect the prognosis.

_____ Swelling, sensitivity, pain and infection are possible during and after RCT (antibiotics may be needed.)

_____ I may be given injections of local anesthetics. Occasionally, during these injections, I understand that the needle can injure a nerve to my tongue or lip leading to temporary, prolonged, or permanent loss of feeling along the path of the nerve.

_____ Reactions to anesthetic injections may result in swelling, allergic reaction or hematoma (temporary discoloration of skin of face).

_____ The tooth may be fractured, but not detectable (causing persistent biting pain)

_____ Jaw cramps and muscle spasms can occur (i.e., TMJ difficulty).

_____ Damage to bridges, existing fillings, crowns, chipping of porcelain, and loss of tooth structure while obtaining access to the canals may occur. The tooth and/or root(s) may crack after RCT, possibly resulting in loss of tooth. If no crown is present, one usually should be made within 3 to 4 weeks.

_____ Referred pain to ear, neck and head is possible for 2 to 3 days after RCT.

_____ Antibiotics may cause diarrhea, abdominal cramps, colitis and allergic reactions (hives). CALL to notify the doctor of any of the these complications.

_____ It is not unusual to have biting sensitivity up to 4 weeks after RCT.

_____ Temporary drowsiness/ lack of coordination from oral sedative medications/nitrous oxide (laughing gas) may occur.

_____ Antibiotics may reduce effectiveness of birth control pills (inform doctor).

_____ Minor burn of lip, tongue, or cheek from heated instrument may occur.

_____ No guarantee or assurance can be given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my present condition would occur sooner without the recommended treatment (possibly leading to infection).

_____ I certify that I speak, read and write English and have read and fully understand this consent for treatment.

PLEASE ASK YOUR DOCTOR, IF YOU HAVE QUESTIONS

CONCERNING THIS CONSENT FORM.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date