DENTAL SPECIALTY CENTER
FALCON

CONSENT FOR ENDODONTIC TREATMENT

I understand root canal treatment is a procedure to retain a tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

I, the undersigned, have been informed that I require an endodontic procedure (root canal treatment) on tooth number (s) _____ and that I fully understand the following:

1. Failure to follow this recommendation will most likely result in:
    a. The loss of the tooth.
    b. Bone destruction due to an abscess.
    c. Possible systemic (affecting the whole body) infection.
2. A failing root canal may require re-treatment, periapical surgery and even extraction depending on the clinical situation.
3. During instrumentation of the tooth the following may occur: a communication with the periodontal structures, an instrument separation in the root canal system, and an overextension of the root canal cement or filling material. Although they are rare and usually do not have a negative effect on the prognosis, these events may lead to nonhealing of the root canal.
4. When making an access (opening) through an existing crown or placing a rubber dam the crown may chip or fracture and a new crown may be necessary after the endodontic treatment.
5. Successful completion of the root canal procedure does not prevent future decay or fracture.
6. Temporary fillings are usually placed in the tooth immediately after root canal treatment. Teeth which have had root canal treatment will require a permanent restoration. This may involve a filling or more extensive restorative work (pins, post, crown build-up, crown) depending on the clinical status of the tooth. If the tooth is not properly restored it could fracture/break requiring extraction.

I understand that a series of appointments may be necessary to complete the root canal therapy, as well as other appointments for restoration. I am also aware that I may have the following symptoms throughout the treatment. Those symptoms may include, but are not limited to: swelling, pain, infection, drainage, fever, and numbness. There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the Doctor of any previous side effects or allergies.

Note: Antibiotics may decrease the effectiveness of birth control medication. Additional methods of birth control should be used while on antibiotics.

Your estimated copay for today's procedure is _____. Payment will be collected at the end of today's appointment.

RISKS AND COMPLICATIONS OF LOCAL ANESTHETIC USE. I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: *nerve injury* resulting in *altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.*

I understand that during treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent structures or teeth. I therefore consent to

such additional or alternative procedures as may be required in the best judgment of the treating dentist.

I can read and write English. I have been given ample opportunity to discuss with my doctor & ask any questions regarding the nature, purpose, risks, treatment alternatives (including non-treatment) & fees associated with the proposed treatment. My questions have been answered satisfactorily. I voluntarily assume any & all possible risks which may be associated with any phase of this treatment in hopes of obtaining the desired result.

Signed: _____ Date: _____
Patient or Legal Guardian

Signed: _____ Date: _____
Treating Dentist