Avery Ranch Dental

Consent for Root Canal Therapy

_____ _____

Patient's Name *Date*

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

_____ 1. ROOT CANAL THERAPY:
I realize root canal therapy has a very high success rate; however, there is no guarantee the root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth not restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough might need further surgery or treatment by a specialist at additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which, if not placed right away, might lead to fracture of the tooth and possibly extraction.

_____ 2. DRUGS AND MEDICATIONS:
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. RISKS OF DENTAL ANESTHESIA:
I understand that pain, bruising and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with local anesthetics. About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

_____ 4. Due to the unique differenced in each patient's oral cavity and oral hygiene abilities there is a risk for relapse, recurrence, and failure of restorations. It is the doctor's opinion that therapy will be helpful and worsening of the conditions would occur sooner without the recommended treatment

_____ 5. CHANGES IN TREATMENT PLAN:
I understand that during the course of treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care and understand that the fee proposed is subject to change, depending upon those unforeseen or undiagnosed conditions that may only become apparent once treatment has begun.

CONSENT: I have had the opportunity to have all my questions answered by my doctor. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____ _____

Patient's or Guardian's Signature Date

_____ _____

Doctor's Signature Date

_____ _____

Witness' Signature Date