

## CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

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

You have the right to be informed about your condition and the recommended treatment plan so that you make an informed decision as to whether or not to undergo the procedure knowing the benefits and risks involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

PATIENT NAME: \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ 1. I hereby authorize Dr. \_\_\_\_\_, and any other agents, assistants or employees selected by him, to treat the condition(s) described as:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ 3. I have been informed of possible alternative methods of treatment (if any), including:  
\_\_\_\_\_  
\_\_\_\_\_

I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

- \_\_\_\_\_ 4. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:
- \_\_\_\_\_ A. Following the appointment teeth may be **sensitive** and postoperative **discomfort and swelling** may occur. In this case **over the counter or prescription pain medication** may be needed.
  - \_\_\_\_\_ B. Prolonged or heavy **bleeding** that may require additional treatment.
  - \_\_\_\_\_ C. **Injury or damage** to adjacent tooth roots, clinical crowns or fillings of teeth, necessitating additional procedures.
  - \_\_\_\_\_ D. Postoperative **infection** may occur requiring additional treatment or medicine.
  - \_\_\_\_\_ E. Stretching of the corners of the mouth that may cause **cracking and bruising** which may heal slowly.
  - \_\_\_\_\_ F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the joints of the jaw (**TMJ**).
  - \_\_\_\_\_ G. **Numbness or tingling** of the lips, gums, chin and/or tongue which may last from several days to several months; or partial or total numbness which may last forever (be permanent).
  - \_\_\_\_\_ H. **Medications/irrigants** used can be caustic to tissue outside of tooth and may cause tissue damage.
  - \_\_\_\_\_ I. Perforation of the **sinus**(Upper teeth only) during root canal treatment, resulting in an oral-sinus communication, necessitating additional treatment to correct the problem (usually referral to specialist).

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- \_\_\_\_\_ 5. I understand that a **fractured or split root(s) may exist** which may be difficult to detect or confirm, and that this may result in eventual failure of the treatment and could require extraction of the involved tooth or teeth. If the fracture or split is detected at the time of procedure and cannot be treated, the involved tooth or teeth **may need to be extracted** (at that time or later time). The patient will be informed if this occurs and will be given the option of extraction.
- \_\_\_\_\_ 6. Root Canal therapy is **about 95% successful**. **Many factors** influence the outcome: the patient's general health, bone support around the tooth, strength of the tooth, possible undetected tooth fracture, shape and condition of the root and nerve canal(s), infection, etc. This means **results cannot be guaranteed**.
- \_\_\_\_\_ 7. Teeth treated for root canal therapy must be protected during treatment. Between appointments you may have a **temporary filling**, unless an infection requires drainage through the tooth. If this filling should be lost please contact us as soon as possible to arrange for replacement.
- \_\_\_\_\_ 8. **Fractures during the course of treatment** are one of the main reasons why root canal treatment fails. **TRY NOT TO EAT ON THE TREATED TOOTH UNTIL A PERMANENT CROWN IS PLACED. AVOID CHEWING ON HARD FOOD/ OBJECTS LIKE ICE, HARD CANDIES, ETC. A FRACTURED TOOTH MAY REQUIRE EXTRACTION OR OTHER FORMS OF ADDITIONAL TREATMENT.**
- \_\_\_\_\_ 9. **FINAL RESTORATION** OF THE TOOTH IS REQUIRED. THIS TYPICALLY INVOLVES A BUILD-UP FILLING AND CROWN. GUM SURGERY TO RECONTOUR GUMS AND/OR BONE MAY BE REQUIRED. A POST FOR RETENTION ALSO MAY BE REQUIRED. WE TRY TO PLAN IF THESE MAY BE NECESSARY. HOWEVER, IT CAN NEVER BE 100% PREDICTABLE AND TREATMENT PLANS MAY CHANGE DURING THE COURSE OF TREATMENT. THESE ARE SEPARATE FEES.
- \_\_\_\_\_ 10. In some situations root canal treatment alone may not resolve the problem and **surgical endodontics or retreatment** may be required. This usually involves referral to an Endodontist (Root Canal Specialist).
- \_\_\_\_\_ 11. During the course of treatment a file or other **instrument can become broken**. We make every attempt to prevent this – high quality instruments, technique, etc. However, sometimes instrument breakage happens. If this happens you will be informed of its occurrence and treatment options, which may range from an observation to referral to an Endodontist.
- \_\_\_\_\_ 12. It has been explained to me that during the course of the procedure(s) **unforeseen conditions** may be revealed which will necessitate extension of the original procedure(s) or different procedure(s) from those set forth in Paragraph 2. above. I authorize my doctor and his staff to perform such procedure(s) as are necessary and desirable in the exercise of professional judgment.
- \_\_\_\_\_ 13. If you have an **existing crown** it is recommended that the crown be replaced as trying to accomplish a root canal through the crown increases the difficulty and therefore increases the risk of complication and decreases the chance of success. Also, the cement bond can be disturbed unknowingly causing early failure. Additionally, the existing crown may mask the cause of pulpal change leading to root canal failure.

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- \_\_\_\_\_ 14. I consent to the administration of **local anesthesia** in connection with the procedure(s) referred to above.
- \_\_\_\_\_ 15. I have been made aware that certain medications and prescriptions that I may be given can cause drowsiness, disorientation, and lack of awareness, which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery, and not to work while taking such medication, or until fully recovered from the effects of same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication.
- \_\_\_\_\_ 16. I am aware that Dr. Steinhubel is a **GENERAL DENTIST** who has advanced training and equipment to perform this standard procedure. I am aware that I can be referred to a root canal specialist. (**ENDODONTIST**) at my discretion. Additionally, If certain difficulties arise during the procedure it may need to be stopped and referral to a specialist given for completion of the procedure.
- \_\_\_\_\_ 17. I understand that **photographs** and movies may be taken of this procedure, and that they may be viewed by staff for records and training purposes. I consent to the taking of such pictures subject to the following conditions:  
\_\_\_\_\_ A. The name of the patient and his/her family is not used to identify said pictures.  
\_\_\_\_\_ B. Said pictures be used only for purposes of medical/dental study, training, or research.

**CONSENT:** I have read and understand the above paragraphs and realize that a perfect result cannot be guaranteed. All my questions have been fully answered to my satisfaction regarding this consent and I fully understand the risks involved. I also state that I speak, read, and write English.

\_\_\_\_\_  
Patient's (or legal guardian's) signature

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness' signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's signature

\_\_\_\_\_  
Date