Bayside Endodontics
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INFORMATION AND CONSENT FOR ENDODONTIC (ROOT CANAL) EXAM/TREATMENT

1. I hereby authorize the doctor and/or designated staff to provide any necessary treatment for the diagnosis and care of my dental needs.

2. I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such risks include but not limited to, the following:
   A. Post-operative discomfort, swelling, and infection: Following treatment, you may experience pain, swelling, and discomfort for several days, which may be treated with pain medication. You may also experience an infection following treatment, which would be treated with antibiotics.
   B. Reaction to anesthesia and/or sedation: You will receive a local anesthetic and possibly a sedative (tranquilizer) to keep you comfortable during treatment. In rare instances, patients have an allergic reaction to the anesthetics which may require emergency medical attention. Sedatives may cause drowsiness and lack of awareness or coordination, which can be increased by alcohol or other drugs. You are advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications. Transportation must be arranged prior to appointments at which sedatives will be needed.
   C. Stiff or sore jaw joints: Holding your mouth open during treatment may temporarily leave your jaw feeeling stiff and sore,and may make it difficult for you to open your mouth wide for several days afterwards. Treatment may also leave the corners of your mouth red or cracked for several days.
   D. Perforation of the root or crown of the tooth, which may be repaired, or may necessitate extraction of the tooth.
   E. Separation of a file in the root of the tooth: The separated segment may be removed or left in place and incorporated into the root canal filling.
   F. Inability to instrument and fill root canal(s) completely to the root end(s): This may or may not result in a compromised long term prognosis for the treated tooth.
   G. Changes to nerve sensations: The nerves that control sensations in your teeth, gums, tongue, lips, and chin run through your jaw. Any treatment on teeth close to these nerves may result in changes in the normal sensations in any of these areas, causing itching, tingling, or burning (called paresthesia) or the loss of all sensation (called anesthesia). These changes could last from several weeks to several months, or in some cases, indefinitely.
   H. I understand that if there is an existing restoration on the tooth- the doctor will need to drill through or possibly remove the crown in order to perform endodontic treatment. Though every effort will be made to preserve the crown, damage to the crown is an inherent risk of the procedure. I understand that should the crown need to be replaced, I will need to return to my general dentist and will assume full financial responsibility for such treatment.

3. I understand that during the procedure(s), unforeseen conditions may be revealed which may necessitate a change in treatment plan, in which case the dentist will explain to me the change and the reason for it.

4. I understand that not treating this condition could cause problems, including, but not limited to: worsening of the abscess; sinus, jaw, or facial infections; loss of tooth or teeth.

5. I understand that successful endodontic treatment requires conscientious plaque removal by the patient (brushing, flossing, and other procedures recommended by the dentist), periodic recall visits for observation, and the restoration of the tooth with a crown. I understand that timely placement of a crown and/or build-up on teeth have been endodontically treated is essential to avoid fracture and/or reinfection of the root canal space. Upon completion of root canal therapy, I will be referred back to my general dentist for placement of a final restoration.

6. I understand that every reasonable effort will be made to ensure that my condition is treated, although it is not possible to guarantee perfect results. By signing below, I am acknowledging that I have received adequate information about the proposed treatment, that I understand this information, and that all of my questions have been answered fully.