

INFORMED CONSENT

Root Canal

I understand that the treatment of my dental condition requiring a root canal includes certain risks and potential unsuccessful results with even the possibility of failure. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (Even though care and diligence is exercised in the treatment of conditions requiring a root canal, there are no promises or guarantees of anticipated results or the longevity of the treatment). I also understand that this procedure can be performed by an endodontist (a root canal specialist).

Nature of Endodontic Treatment: Root canal treatment (also called endodontic treatment) requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root(s). It is done by first making an opening through the chewing surface of the tooth to gain access to the tooth's pulp. The contents of the canals are removed and the canals cleaned and shaped. The canals are then cleaned and sealed with an inert, rubbery material called gutta percha. Following root canal treatment, the tooth will need a final restoration, usually a crown, to return to its proper function. The final restoration is not part of this discussion and consent.

Alternatives to Endodontic Treatment: Depending on my diagnosis, there may or may not be alternatives to root canal treatment that involve other types of dental care. I understand the two most common alternatives to root canal treatment are to have the tooth removed or to do nothing. If I have the tooth removed then it usually requires replacement by an artificial tooth by means of a dental implant, fixed bridge, or removable partial denture. If I choose no treatment, my condition may worsen and I may risk serious personal injury, including severe pain; localized infection; loss of this tooth and possibly other teeth; severe swelling; and/or severe infection that may be potentially fatal.

Risks of Endodontic Treatment: I have been informed and fully understand that there are certain inherent and potential risks associated with root canal treatment. I understand that during and after treatment I may experience pain or discomfort, bleeding, swelling, changes in my bite, and, loosening or loss of dental restorations. I understand that it is possible for an infection to occur or an existing infection to worsen in the tooth being treated and/or in the area around the tooth, and that I might need antibiotics and/or other procedures to treat the infection. I understand that root canal instruments sometimes separate (break) inside the canal. This is more likely when canals are curved and/or narrowed. If the separated fragment cannot be retrieved, it may need to be sealed inside the root canal. It may also be necessary to have oral surgery performed on the tooth root (apicoectomy) to address the problem. I understand that a separated instrument often decreases the likelihood of clinical success. I understand that other risks include: perforation of the tooth or tooth root by an instrument; injury to soft tissues adjacent to the tooth; sinus perforation; and nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling or the lip, tongue, chin, teeth and/or mouth tissues.

Acknowledgement: I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays. I realize that in spite of the possible complications and risks, my recommended root canal treatment is necessary.

Injury to the nerves: Surgical procedures or local anesthesia may possibly result in injury to the nerves of the lips, tongue, or other oral tissues. Numbness could occur which may be either temporary or permanent.

Patient responsibility: It is the patient's responsibility to seek attention should any undue or unexpected problems occur and also to diligently follow any instructions, including the scheduling and attending of all appointments.

Informed consent: I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Phillips and/or his associates to render any treatment deemed necessary, desirable and/or advisable to my dental conditions.

