WICHITA FALLS ENDODONTICS

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ENDODONTIC TREATMENT CONSENT

If I require Endodontic therapy (i.e., root canal treatment), I, the undersigned, do hereby acknowledge that I fully understand the following considerations related to Endodontic treatment and do hereby consent to said treatment. I also understand and acknowledge that no treatment will be performed without my request and consent.

1. Endodontic treatment is performed as an attempt to retain a tooth which may require extraction. Although Endodontic treatment has a high degree of clinical success, it is still a biological procedure and success cannot be guaranteed. A certain percentage of Endodontically treated teeth ultimately may require further treatment, such as re-treatment, surgical treatment or extraction. Additional treatment does not guarantee success.
2. When making an Endodontic access opening through an existing restoration or placing a rubber dam clamp, damage to the restoration could occur, necessitating repair or replacement of the restoration by your general dentist.
3. Successful completion of the root canal procedure does not prevent future decay or fracture of the treated tooth.
4. Most risks related to Endodontic treatment are rare & include, but are not limited to: inability to locate canal(s), perforation of the tooth or root, inability to treat to the end of root (underfill), filling material out the end of the root (overfill), instrument separation, inability to remove previous root canal filling materials, weakening of the tooth, tooth or root fracture, restricted jaw opening (trismus), possible need for treatment of a second tooth, sinus involvement, transient or permanent parasthesia. Other factors which may influence the outcome of treatment include, but are not limited to, my overall health, level of anxiety, anatomy of my tooth, or location of leakage of temporary or permanent restorations placed after completed treatment.
5. There are risks associated with the administration of anesthetics, analgesia, and antibiotics, such as pain, swelling, hives, infection, or intestinal complications. I will inform the doctor of any previous side effects or allergies and will report any complications to the office immediately.
6. I understand that I have alternatives to treatment which include, but are not limited to, having the tooth extracted or deciding not to have treatment, although not treating the tooth can lead to an abscess or larger infection.
7. I have reviewed the HIPPA notification form that was provided to me during my initial appointment or reviewed online at the website stated above.
8. Upon completion of Endodontic treatment, I will return to my general dentist's office, within 4 weeks, for the permanent restoration of the treated tooth.

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Signature of Patient or Guardian Signature Date

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Printed Name