ENDODONTIC
SPECIALISTS, P.A.

Endodontic Therapy and Endodontic Microsurgery

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Patient Name _____

INFORMATION ABOUT ENDODONTIC TREATMENT

Please review the following consent. You will be required to sign it prior to the initiation of your examination: however, it does not commit you to treatment.

I understand endodontic treatment is a procedure to retain a tooth that may otherwise require extraction. Although endodontic treatment has a very high degree of clinical success, it is a biological procedure, so it cannot be guaranteed. Occasionally, a tooth that has had endodontic treatment may require retreatment, surgery or even extraction.

Complications of endodontic treatment and anesthesia may include swelling, discomfort, trismus (restrained jaw opening), infection, bleeding, sinus involvement, and numbing or tingling of the lip, gum or tongue which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately. During treatment there is the possibility of an instrument separating within a root canal, fractures or perforations (extra openings) occurring, or damage to an existing crown, filling or bridge. During treatment, situations may be discovered which can make treatment impossible or, which may require dental surgery.

Endodontic treatment most often requires local anesthesia and I agree to the use of any appropriate local anesthetics. I understand, that only the endodontic treatment is to be performed at this office. The permanent (outside) restoration (filling, crown, etc.) will be done by my regular dentist. I also understand that medications for pain and sedation may cause drowsiness, which can by increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the office immediately.

Other treatment choices include no treatment, waiting for more definitive symptoms to develop or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

This acknowledges that I have read the above and consent to any appropriate diagnostic or consultation procedures only by Endodontic Specialists, P.A. This does not commit me to treatment.

_____ _____

Date Patient's Signature

(ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS 18 YEARS OLD OR YOUNGER.)

PLEASE DO NOT WRITE IN THE SPACE BELOW OR SIGN UNTIL YOU HAVE TALKED TO THE DOCTOR.

Notes _____

Procedure _____ _____ _____ _____

Date Doctor Witness

This acknowledges that I have read the above and consent to any appropriate endodontic procedures deemed necessary or advisable to be performed by Endodontic Specialists, P.A. and was given the opportunity to question the Doctor regarding treatment, its alternatives and prognosis. This consent does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

_____ _____

Date Patient's Signature

(ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS 18 YEARS OLD OR YOUNGER.)