Root Canal Informed Consent

I request and authorize Dr. Joiner or Dr. Zwart or their associates to perform ROOT CANAL THERAPY and such additional procedures as are considered necessary on the basis of findings during the course of said treatment.

PROCEDURE: _____

I have been informed of alternative treatment options, benefits and possible risks and after the dentist's explanation, I have chosen said treatment. I understand there are various inherent or potential risks that can occur as a result of said procedure(s) despite all efforts to the contrary which include but are not limited to:

1. pain, swelling, bleeding, sensitivity, infection and/or bruising which may require additional treatment
2. changes in occlusion (biting), jaw muscle cramps and/or damage to existing restorations which may require replacement
3. damage to nearby teeth during said procedure that may require additional treatment
4. drug reactions and side effects
5. post-operative bleeding or infection that may require additional treatment
6. involvement of the nerve within the lower jaw resulting in temporary (but possible permanent) tingling and/or numbness in the lip, chin, tongue, gums, cheeks and teeth
7. referred pain to ear, neck and head; delayed healing; sinus perforation
8. treatment failure; complications resulting from the use of dental instruments (broken instrument, perforation of tooth, root and/or sinus); discoloration of the face
9. additional treatment may be necessary
10. drainage
11. fever

I understand that I should notify the dentist if any of these symptoms are present for more than 48 hours.

I understand that the administration of anesthesia and/or medications carry certain inherent risks, such as, but not limited to:

1. drug interactions and/or side effects that may cause drowsiness and lack of coordination
2. bruising and/or numbness including the sites of the injection, numbness may rarely be permanent
3. antibiotics may inhibit the effects of birth control pills and other methods of contraception must be utilized during the treatment period

I understand root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require additional treatment, surgery or even extraction.

I also understand root canal therapy is a filling of the internal canals of the tooth and that a final outside restoration (usually including a build-up and crown) will be necessary following root canal treatment. Since the blood supply is removed from the tooth, it has a tendency to become more brittle and may discolor.

I further understand that this procedure(s) can also be performed by a specialist and prefer that this treatment be rendered in this office by a general dentist.

The dental care and treatment to be performed has been explained to me and I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure. I may ask the attending dentist for a more complete explanation.

This is my consent for said procedure(s), anesthetics and x-rays to be taken. I hereby acknowledge I have completely read and understand the foregoing; have been given the opportunity to discuss this form and question the dentist concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment, and have been given satisfactory answers and agree to proceed with recommended procedure(s). I am aware the practice of dentistry is not an exact science and acknowledge that no promises or guarantees of results have been made nor are expected. This consent form does not encompass the entire discussion I had with the dentist regarding the proposed treatment.

_____ _____ _____ _____

Patient (Guardian) signature **Date** **Witness signature** **Date**