Microsurgical Endodontics

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Specialist Members

Consent for Endodontic Treatment

Do NOT sign this form until you have had a chance to speak with the doctor.

Information Regarding Treatment:

Prior to treatment, the doctor will examine the area of concern and make a recommendation of treatment. Usually, there is more than one treatment option available.

The procedure the doctor has recommended for me is: Endodontic (Root Canal) Treatment

Endodontic (Root Canal) Retreatment

The overall prognosis (outlook or expectation that the treatment will be successful) is _____

I am aware that once treatment is completed, the doctor will place a temporary filling in the tooth. I will need to follow up with my regular dentist for permanent restoration of the tooth which may be a filling and/or a crown. Failure to do so in the next 6 weeks may result in the temporary filling breaking down and contamination of the root canal, which would require additional root canal treatment.

There are certain inherent and potential risks in any treatment or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive:

Pain or sensitivity during or after the procedure; infection; swelling; bleeding; need for additional root canal procedures (non-surgical or surgical); treatment failure including possible need to have the tooth extracted (removed); changes in occlusion (biting); jaw muscle and joint (TMJ) pain or tenderness; referred pain to ear, neck and head; delayed healing; reactions or complications from injections or the use of anesthetics or medications including allergic reactions, drowsiness, lack of coordination, or nausea. Need for antibiotics which may inhibit (interfere with) the effectiveness of birth control pills; complications resulting from the use of dental instruments (broken instruments or perforation of the tooth, root, or sinus); numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; and discoloration (bruising) of the face.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

The questions I have concerning the nature of treatment, the inherent risks of treatment, and the alternatives to this treatment have been answered to my satisfaction.

Patient's signature_____ Date_____

Doctor's initials_____

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