

Alpha Canyon Endodontics Informed Consent For Endodontic Therapy

You are required to sign this consent prior to consultation / treatment. However, it does not commit you to treatment.

This is my consent to the endodontic procedures and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any endodontist and his assistants. As a specialty practice, this office performs *only* endodontic therapy and associated surgery. I agree to the use of local anesthesia as needed. I understand that the endodontist will consult with me prior to administering any sedation, and / or nitrous oxide analgesia. **Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, inflammatory or allergic response to materials, or numbness 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.**

I understand that root canal therapy is a biological procedure to retain a tooth, which may otherwise require extraction. Although endodontic therapy has a very high degree of success, a successful result *cannot* be guaranteed. It is our professional goal to provide you with the *best* possible treatment in a *caring* and *comfortable* manner.

Occasionally, a tooth that has had root canal therapy may require re-treatment, surgery, or even extraction. Following treatment my tooth may be brittle and subject to fracture. A timely and properly placed restoration (filling/crown/post & core) is necessary to maintain the integrity of the root canal treatment and to restore my tooth to function. My family dentist will perform this restoration. **I understand that the fee for the root canal treatment does not include the restoration of my tooth.** I further understand that if my tooth is not timely and properly restored after endodontic therapy, failure of the root canal treatment may occur due to re-contamination and require re-treatment or extraction at my expense.

During treatment there is the possibility of instrument separation within the root canals; over-or under fill; loss of tooth structure and/or damage to existing crown/bridge or porcelain veneers in gaining access to canals; discovery of an unstable base due to decay or other causes; perforations (extra openings); missed canals, and fractured teeth or roots. Also, there are times when minor surgical procedure may be indicated, or when my tooth may not be amenable to endodontic treatment, retreatment, or surgical endodontics at all.

Other treatment choices include no treatment; waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices may include, but are not limited to pain, infection, loss of teeth, and infection to other areas.

Medications may be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or 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 endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

I give my permission for taking video, X-ray, and photographic images of my mouth and teeth for teaching and educational purposes.

Once treatment has begun, it is absolutely necessary that the root canal treatment be completed. The root canal treatment may require more than one appointment to be completed.

NOTES / QUESTIONS _____

Date _____

Patient signature _____

A parent/guardian must sign if patient is under the age of 18