253 DENTAL CARE

Dentistry Dedicated to Excellence

Consent for Endodontic Therapy

I, _____, hereby authorize Dr. Walker to perform the

following procedure:_____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment. The doctor has also informed me that there are certain potential risks associated with this treatment plan or procedure that may occur despite the experience and skill of the doctor.

I UNDERSTAND that **ENDODONTIC ROOT CANAL THERAPY** includes possible inherent risks such as, but not limited to the following and I agree to accept any and all such risks:

These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
2. Postoperative bleeding requiring additional treatment.
3. Postoperative infection requiring additional treatment.
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings.
6. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
7. Stretching of the corners of the mouth with resultant cracking and bruising
8. The need for additional surgeries.
9. Damage to existing fillings, crowns, and porcelain veneers.
10. Perforation of the crown or root during endodontic access which may result in the need to extract the tooth.
11. Cracked, fractured, or perforated roots which may result in the need to extract the tooth.

12. Broken instruments that may not be removable from the tooth.

13. Under or overfilling the roots with gutta percha which may affect the apical seal and success of treatment.

14. Anatomic relationships of the tooth that may affect the apical seal and success of treatment such as open root ends, curved roots, small non-negotiable roots, and supplemental or lateral canals.

15. _____

I have been given the opportunity to ask any questions regarding the nature and purpose of this treatment known as **Endodontic Root Canal Therapy** and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. Walker to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize Dr. Walker to perform such procedures when, in their professional judgment, they are necessary. I also verify that I have provided a complete and accurate medical history that includes all medications, drug use, allergies, previous surgeries, and pregnancy information and history. I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase the effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask the doctor or staff if you have any questions.

_____
Patient, parent or guardian

_____ _____
Doctor Date