1358 SE University Ave
Waukee, IA 50263
Phone: 515-393-2556

PRAIRIE
— ENDODONTICS —

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CONSENT FOR ROOT CANAL TREATMENT

Patient Name: _____ Date: _____

Consent for root canal treatment on tooth #_____.

Please read and initial the following information regarding your root canal therapy.

1._____. I understand that root canal therapy is a procedure to save an otherwise hopeless tooth. Extraction is the only definitive alternative.

2._____. Although root canal therapy has a high success rate, many factors contribute to its success or failure which may not be possible to determine in advance. No guarantee of successful treatment can be given or implied. Therefore, unforeseen factors may result in the need for extraction. Some of the causes of failure include, but are not limited to: resistant bacteria, irregular shape and location of root anatomy, periodontal (gum) disease, tooth fractures, a failure to keep scheduled appointments, or the failure to have the tooth restored promptly after the completion of treatment.

3.____. I understand that a permanent restoration will need to be placed after endodontic therapy. The endodontic treatment does not include these restorative procedures and I understand that it is my responsibility to follow up with my dentist to have an appropriate restoration placed following the root canal procedure.

4.____. Periodic recall examinations of the tooth to include radiographs are recommended to evaluate the success of treatment rendered. Compliance is the patient's responsibility.

5.____. Treatment will be performed in accordance with accepted methods of clinical practice. This includes the administration of local anesthetic, placement of a rubber dam and a number of radiographs taken throughout the procedure.

6.____. Possible complications of treatment include, but are not limited to:

- Discomfort during or following treatment such as soreness of the tooth and surrounding structures, jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty
- Infection or swelling
- Procedural difficulties like the separation of instruments in the root canal space, perforations of the crown or root, damage to existing fillings, crowns or bridges
- Discovery of a fracture in the crown or root
- Additional unknown or unspecified problems, the explanation for and responsibility of which cannot be given or assumed. Occasionally complications may be discovered which make treatment impossible requiring endodontic surgery or extraction of the tooth.

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7.___. I understand potential complications of anesthesia, injections, and prescribed pain medications exist. This may include, but are not limited to: swelling, infection, bleeding, discoloration of the face, discomfort, pain, nausea, drowsiness, allergic reactions, numbness or tingling of the lip, gum, or tongue. Numbness (loss of feeling), if present, usually resolves in weeks or months but could remain permanently.

8.___. I am free to withdraw my consent and discontinue treatment at any time; however, complications such as bone destruction, infection, swelling and/or pain, etc., may predictably occur if the endodontic therapy is not completed.

9.___. The number of treatment visits required to complete treatment is dependent on a multitude of factors. I am aware that multiple appointments may be needed to complete treatment.

10.___. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

Patient signature: _____

Date: _____

Witness: _____