Informed Consent for Root Canal Treatment

Dentist: Dr. Kaushali Patel **Patient:**

Tooth #:

FACTS FOR CONSIDERATION

I have been advised by my dentist that I have a tooth requiring Root Canal Treatment. Root Canal Treatment, also called endodontic treatment involves removing the nerve tissue (called pulp) located in the center of the tooth and its root or roots (also called the root canal). Treatment involves creating an opening through the biting surface of the tooth to access the pulp or its remnants, which are then removed. Medications may be used to disinfect the interior of the tooth to prevent further infection. Root Canal Treatment may relieve symptoms such as pain and discomfort. If any unexpected difficulties occur during treatment, I may be referred to an endodontist, who is a specialist in Root Canal Treatment. Each empty root canal that can be located is filled with a rubber-like material and medicated cement. Occasionally a metal pin (called a post or rod), is inserted into one or more canals to help restore the tooth. The opening in the tooth is closed with a temporary filling. A crown (cap) may also be required to prevent tooth fracture. A crown is a separate dental procedure and is not included in this discussion. Twisted, curved, accessory, or blocked canals may prevent removal of all inflamed or infected pulp and complete filling of the root canal(s). Since leaving any pulp in the root canal may cause your symptoms to continue or worsen, this might require an additional procedure called an apicoectomy. Through an opening cut in the gums and surrounding bone, any infected tissue is removed, and the root canal is sealed. An apicoectomy may also be required if symptoms continue and/or if the tooth does not heal.

Once the Root Canal Treatment is completed it is essential to return promptly to have treatment on the tooth completed. Because a temporary filling is designed to last only a short time, failing to return as directed by your dentist or endodontist to have the tooth sealed permanently with a crown or filling can lead to other problems such as deterioration of the temporary filling resulting in decay, bacteria leaking into the root canal(s) causing infection, gum disease, tooth fracture, and the possible premature loss of the tooth.

I understand that if no treatment is administered my discomfort may continue and I may face the risk of a serious, potentially life threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually loss of my tooth and/or adjacent teeth.

________ (Initials)

RISKS OF ROOT CANAL TREATMENT, NOT LIMITED TO THE FOLLOWING

Treatment is not without some risk. I have been informed of the possible risks and complications involved with Root Canal Treatment, any medications to be used, and local anesthesia. Such complications include post-treatment pain, swelling, continued infection, prolonged sensitivity of the teeth and possible recession of the gumline. There is always a slight possibility that numbness of the lip, tongue, chin, cheek, or teeth may occur following any injection. The exact duration of this numbness may not be determinable and may be irreversible. Also possible are injury to teeth or implant present, delayed healing, and allergic reactions to drugs or medications used, etc. I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible infection can accompany Root Canal Treatment and may be treated with antibiotics or other procedures. I will contact the dental office immediately if conditions worsen, if symptoms persist beyond a few days, or if I experience fever, chills, sweats, or numbness.

I understand that I will receive a local anesthesia and/or other medication. I agree to the type of anesthesia and other medications prescribed according to the choice of the doctor. In rare instances patients have a reaction to the anesthetic or other medications, which may require emergency medical attention at my cost. Some patients find that local anesthesia reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary, or permanent nerve injury can result from an injection of local anesthetic. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and make it difficult for me to open wide for several days afterwards. However, this can occasionally be an indication of a further problem. I must notify the dental office if this or other concerns arise.

I understand that occasionally a root canal instrument may break off in a root canal that is twisted, curved, or blocked with calcium deposits. Depending on its location, the fragment may be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical stainless steel or titanium, so this usually causes no harm). It may also be necessary to perform an apicoectomy, as described above, to seal the root canal, or I may be referred to an endodontist for further treatment. I understand that during treatment the root canal filling material may extrude out the end of the root canal into the surrounding bone and tissue. Occasionally an apicoectomy may be necessary for retrieving the filling material and sealing the root canal, or I may be referred to an endodontist for further treatment.

I understand that following a Root Canal Treatment a tooth may be more prone to cracking and breaking over time, which may require removal of the tooth and replacement with a fixed (cemented bridge), removable partial denture (appliance), or implant (artificial tooth). The presence of Gum Disease (Periodontal Disease) can increase the chance of losing a tooth even though Root Canal Treatment is successful. I understand that Root Canal Treatment may not relieve my symptoms and in this case my dentist may refer me to an endodontist, or I may need my tooth extracted.

I request and authorize medical/dental services for myself, including Root Canal Treatment and other related treatment. I fully understand that during the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modifications in design, materials, or care, if my doctor determines this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated, I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the treatment.

________ (Initials)

BENEFITS OF ROOT CANAL TREATMENT, NOT LIMITED TO THE FOLLOWING

Root Canal Treatment is intended to allow you to keep your tooth for a longer time, which will help maintain your natural bite and the healthy functioning of your jaws. This treatment may be recommended to relieve such symptoms as pain, swelling, sensitive teeth, and pain on biting, or from cold or heat.

________ (Initials)

Dentist: Dr. Kaushali Patel | Patient: ____

Tooth #: ____

ALTERNATIVE TREATMENTS IF ROOT CANAL TREATMENT IS NOT THE ONLY SOLUTION, NOT LIMITED TO THE FOLLOWING

I understand that depending on my condition, alternatives to root canal treatment may exist which involve other disciplines in dentistry. Extraction of my tooth is the most common alternative to Root Canal Treatment. This may also require replacing the extracted tooth with a removable partial denture (appliance), a fixed (cemented) bridge or an artificial tooth called an implant. I have asked my dentist about these alternatives and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

____ (Initials)

In conclusion, I understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve the condition(s) listed above. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. I understand if I have taken or take medication for osteoporosis or bone cancer treatment that is a bisphosphonate (such as but not limited to: Zometa, Aredia, Fosamax, Boniva, Actonel), on rare occasions osteonecrosis (lack of blood to the jaw bone cells cause these cells to die) of the jaw may occur after an extraction and/or surgery. Therefore, it is critical that I tell my dentist of all medications and vitamins I am currently taking, which I have done.

	Initials
I consent to the Root Canal Treatment(s) described above.	____
I have been informed of and accept the consequences if no treatment is administered.	____
or	
I refuse to give my consent for the proposed treatment as described above.	____

By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information, and that all my questions have been answered to my satisfaction.

Signature of Patient / Parent / Guardian ____ Date ____

FOR COMPLETION BY DENTIST

I attest that I have discussed the risks, benefits, consequences, and alternatives to Root Canal Treatment with my patient who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Signature of Dentist ____ Witness ____