

ROOT CANAL SPECIALISTS, P.C.

NAME \_\_\_\_\_  
CHART NO. \_\_\_\_\_

**CONSENT FOR ENDODONTIC TREATMENT WITH SEDATION**

NOTE: You will be required to read this prior to treatment, but it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists employed by Root Canal Specialists, P.C., and any assistant(s) they may require. I agree to the use of local anesthesia, in addition to the IV sedation administered by \_\_\_\_\_, depending upon the judgment of the endodontist.

I understand that the goal of root canal therapy is to retain teeth, which may otherwise require extraction and that as a specialty practice; the office performs only endodontic therapy and associated surgery. **Although root canal therapy has a very high degree of success, a perfect result cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery, or even extraction. I understand that the only alternative to root canal treatment is extraction.**

**Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), muscle spasms, TMJ (joint) difficulties, infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which may last a few days and rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amenable to endodontic treatment at all. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth to function; this will be performed by my dentist. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.**

At times, medication will 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 operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives, allergic reactions and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I have been informed that antibiotics may interfere with the effectiveness of oral contraceptives (birth control pill). I understand that it is my responsibility to report any changes in my medical history to the endodontist immediately.

DATE: \_\_\_\_\_ DOCTOR: \_\_\_\_\_ ASSISTANT: \_\_\_\_\_

I CERTIFY THAT I HAVE CAREFULLY READ THE ABOVE STATEMENTS ABOUT ROOT CANAL THERAPY AND THAT THE PROCEDURE TO BE DONE HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I HEREBY CONSENT TO TREATMENT. ALL SIGNATURES MUST BE BY A PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE.

**PATIENT'S SIGNATURE:** \_\_\_\_\_