HIGHLAND PARK ENDODONTICS, LTD.
INFORMED CONSENT FOR ENDODONTIC TREATMENT

Patient Name:_____ Date of Birth:_____

TREATMENT:

Patient's Initials Required Indicating Having Read the Paragraph

_____ Root canal therapy, also called endodontic treatment, involves removing the nerve and its surrounding tissue (called pulp) or dead tissue located in the center of the tooth and its roots (called the canal). Root canal treatment is intended to allow you to keep a tooth that would otherwise require extraction. This treatment is being recommended for you in order to resolve the problems related to the diagnosis made.

_____ Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp which are then removed from each canal that can be located. Medications and solutions may be used during treatment to disinfect the interior of the tooth in order to resist further infection. Each empty canal within the root is then filled, and the opening in the tooth is closed with a temporary restoration. Treatment usually requires one or two visits, but more appointments may be required. During the course of treatment x-rays will need to be taken.

_____ Once the root canal treatment is completed, it is essential to return promptly to your general dentist to permanently restore the treated tooth. A crown is oftentimes necessary. **The permanent restoration should be initiated within four weeks**, but preferably as soon as possible. If your tooth already has an existing crown restoration, it will need to be permanently repaired by your general dentist after the root canal therapy is completed.

RISKS:

_____ If your tooth has an existing crown the crown could come loose during root canal treatment. If the crown is made of or covered by porcelain or porcelain-like materials, it is possible that the crown could chip, break or fracture when entrance is made through the crown in order to perform the root canal therapy. Damage or fracture to the crown could require the crown to need replacement by your general dentist after the root canal therapy is completed. If your tooth has decay under an existing crown, the crown will likely require replacement by your general dentist after the root canal therapy is completed. Failing to return to your general dentist in a timely manner to have the tooth sealed permanently with a filling or a crown can lead to other problems such as deterioration of the temporary seal (resulting in contamination of the just completed root canal), decay, infection, gum disease, fracture, and the possible permanent loss of the tooth. The restoration of the tooth is a separate dental procedure that should be discussed with your general dentist.

_____ Twisted, curved, calcified and/or blocked canals may prevent removal of all of the inflamed or infected pulp and may restrict the movement of root canal instruments within the canal. If an instrument has restricted movement, it may bind within the canal causing the instrument to separate within the canal. Depending on its location, the fragment may be retrieved. At times it may be necessary to seal the fragment within the root canal. The instruments are made of non-toxic surgical stainless steel or nickel titanium, so this usually causes no harm. Also during treatment the root canal filling material may extrude out of the canal into the surrounding bone and tissue. Because the filling materials are biologically compatible, this rarely presents any problems.

_____ It is possible to experience some degree of discomfort, swelling, pain, or bruising after treatment. Pain and infection may be treated with antibiotics and other medications. Local anesthetics are also commonly used during root canal treatment. In rare instances patients can have reactions to medications or anesthetics administered to them, or they can have interactions between medications they are currently taking and those we might prescribe or administer. It is critical that you tell your treating doctor all of the medications that you are currently taking. In rare instances temporary or permanent nerve injury can result from a dental injection.

Additionally, it is possible to experience some discomfort or difficulty in opening your jaw widely after root canal therapy due to the nature of dental procedures.

SUCCESS:

_____ Although root canal treatment has a high degree of success in routine cases it cannot be guaranteed. Teeth that require root canal treatment may be prone to fracture over time especially if they are not restored with a restoration that adequately protects the tooth. If post-treatment disease occurs for any reason, the tooth may require an additional procedure that may include retreatment, surgery (such as an apicoectomy) or even loss of the tooth (extraction).

_____ **A perfect result is neither guaranteed nor warranted and cannot be guaranteed or warranted. No guarantee or assurance has been given to me by anyone at Highland Park Endodontics, Ltd. that the proposed treatment will cure or improve my diagnosed condition.**

ALTERNATIVES:

_____ Depending on the diagnosis, alternative treatments may exist which involve other disciplines in dentistry. These alternatives include removal of the tooth, surgery or no treatment. Although removal of the tooth is the most common alternative to root canal therapy, this may require replacing the missing tooth with a fixed bridge, an artificial tooth implant, or a removable partial denture.

_____ If root canal treatment is not performed, discomfort may develop, continue, or recur. Also, the risk of an infection in the bone and tissue surrounding this tooth, eventually causing the loss of this tooth and/or adjacent teeth is possible. In rare cases serious infections can be life threatening.

AUTHORIZATION:

I hereby authorize the doctors of Highland Park Endodontics, Ltd. to perform root canal therapy on tooth #_____ to treat my dental problem or condition.

Other: _____

I further authorize the administration of medications and anesthetics, performance of diagnostic procedures, and such additional services that may be deemed reasonable and necessary, understanding that risks are involved.

It is acknowledged that this consent form does not encompass the entire discussion regarding the proposed procedure that I had with the doctor.

I have been given the opportunity to ask the doctor questions concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

Patient's Signature _____ Date _____

(This is to be signed after discussion with the doctor.)

Doctor's Signature _____ Date _____

Witness' Signature _____ Date _____