NEVADA ENDODONTICS

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PATIENT INFORMATION AND CONSENT TO TREAT FORM

Welcome, your dentist has referred you to our office for Endodontic Treatment. All treatment involves preliminary diagnostic evaluation and consultation, utilizing x-rays, an oral examination and history, plus appropriate testing.

As an Endodontic Specialty Practice, the office performs only root canals and associated surgery. Endodontic Treatment is utilized to relieve pain and infection in the tooth or teeth and the surrounding jaw tissues. Non-surgical Endodontic Therapy is performed using local anesthesia and consists of the removal of the diseased tissue within the root canals of the tooth, and the sealing of the canal. This therapy is a procedure to retain the tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery or even extraction.

At any time during the following treatment, the tooth may become brittle and may fracture. At the completion of the Endodontic Therapy, you must return to your dentist for an evaluation of the tooth for possible placement of an appropriate restoration (filling, crown and/or post and core) returning the tooth to function.

Possible Risks Associated With Endodontic Treatment

1. Unpredictable reaction to local anesthetics and medication used in connection with treatment.
2. Hairline fractures within the roots of the tooth or teeth in treatment, as well as cracks, fractures, and breaks in the crown of the tooth.
3. Chipping, breaking, or dislodgement of permanently cemented jackets, crowns, inlays, or bridges.
4. Tenderness and soreness of the teeth and gums, along with tingling and swelling of the associated areas.
5. Untreatable canals, stripping or perforation due to; severe canal curvature, severe chamber or root calcifications and/or obstruction.
6. Instruments may separate during root canal therapy, which may not be retrievable.
7. Under fill or Overfill of the filling material (gutta percha) due to the diseased canal system and/or surrounding tissues.
8. On some occasions, at any time in the course of treatment, a surgical approach may become necessary. A separate fee will be quoted for this procedure.
9. Continuation of the infection and need for surgical correction or possible extraction.
10. Temporary/permanent numbness of jaw/lip.

Risks of postponing/deferring Endodontic Treatment:

1. Extraction of the tooth, with loss of function, and esthetics.
2. Formation of the abscesses and cysts in the jawbone.
3. Spread of infection to adjacent teeth and/or oral structures.

I UNDERSTAND THAT WHEN ROOT CANAL THERAPY IS COMPLETED, I MUST RETURN TO MY GENERAL DENTIST TO RESTORE TOOTH WITHIN 4-6 WEEKS. TREATMENT MAY BE UNSUCCESSFUL IF NOT RESTORED IN A TIMELY MANNER. ________ (Initial)

During the course of the treatment every effort will be made to achieve a successful result and keep you as comfortable as possible.

I acknowledge having read the foregoing and understand its contents. I hereby give my consent to treatment.

Signature ____ Date ____________________________

In case of emergency please notify: ____

Relationship: ______________________________________ Phone: ________________________________