Practice Limited to Endodontics and Microsurgery

Consent for Surgical Root Canal Treatment

Patient's Name: _____

Condition(s) Treated: _____

_____

_____

Proposed Treatment: _____

_____

_____

Surgical root canal therapy is a procedure to retain a tooth, which may otherwise require extraction. It is performed on teeth that have had previous root canal therapy but is failing to heal. The treatment involves relieving pain and discomfort associated with a tooth by removing infected and inflamed tissue from around the roots of the teeth and cleaning and sealing the inside of the root ends. Although surgical root canal therapy has a very high degree of clinical success, many factors contribute to its success or failure, which may not be determined in advance. Therefore, a tooth, which has had surgical root canal therapy, may require extraction. Some of these factors affecting outcome include, but are not limited to: the body's resistance to infection; periodontal (gum) disease; a tooth or root fracture that either went undetected or occurred after the treatment; failure to keep scheduled appointments; failure to follow postoperative instructions; or the failure to have the tooth restored promptly or appropriately after completion of the treatment.

I understand that complications of surgical endodontic therapy may include, but are not limited to: the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to existing fillings, crowns or bridges; fracture of the tooth and/or root; discomfort; jaw muscle cramps and spasms, temporomandibular jaw) joint difficulty; swelling, bruising, and pain of the gums and face. During and after treatment, complications may be discovered which make treatment impossible or which may require extraction of the tooth entirely, or extraction of a root. This additional treatment may incur further fees as well, and

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you will be informed of such changes at the time of diagnosis.

I understand that complications of anesthesia, injection, prescribed analgesics (pain relievers) and medicines, and the treatment procedures may include, but are not limited to: swelling, infection, bleeding, discoloration of the face, bruising, discomfort, pain, nausea, drowsiness, allergic reactions, numbness or tingling of the lip, gums or tongue (usually temporary).

❑ I have been informed of possible alternative treatment methods including extraction or no treatment at all.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information, and that all of your questions have been answered fully.

❑ I give my consent for the proposed treatment as described above.

❑ I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision and refuse treatment.

_____

Patient, Parent or Guardian / Date

_____

Dr. Mario Castro / Date