

WHITE BEAR LAKE ENDODONTICS

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This is the consent for Dr. _____ to perform the treatment/procedure as follows:

ENDODONTIC THERAPY involves the removal of the softer portion of the tooth called the pulp with small metal instruments through an access created in the top portion of the tooth (crown). The space inside the tooth is then filled with a rubber-like material and cement to seal the root canals. The root(s) of the tooth remain to secure or anchor the tooth to the jaw bone. Pulp consists of a number of components, including blood vessels and nerve tissue. Cavities, cracks, dental restorations, periodontal disease, and trauma can damage the pulp, thus causing it to degenerate and need treatment.

ENDODONTIC THERAPY requires one to three appointments depending on the degree of infection or inflammation, and the degree of treatment difficulty. The purpose of this treatment is to treat and possibly correct my diseased tooth and/or tissues. I understand there are alternatives to endodontic (root canal) therapy.

They include but may not be limited to:

- 1) No treatment at all. My present oral condition will probably worsen with time and the risks to my health may include but are not limited to: pain, swelling, infection, cyst formation, loss of supporting bone around my teeth, and premature loss of tooth/teeth.
- 2) Extraction with nothing to fill the space. This may result in: shifting of teeth, change in occlusion (bite), periodontal disease.
- 3) Extraction followed by a bridge, partial denture, or implant to fill the space.
- 4) In the case of retreatment (of previously unsuccessful endodontic therapy), endodontic surgery may also be an option.

I understand that there are certain potential risks and complications in any treatment. They include, but are not limited to:

- ___ Postoperative discomfort or sensitivity (with intensity from slight to extreme) lasting a few hours to several days, which may last longer. Most commonly the tooth is temporarily sensitive to biting following each appointment along with slight localized discomfort in the area.
- ___ Postoperative swelling and/or infection in the vicinity of the treated tooth, facial swelling, and/or discoloration of tissues. This may persist for several days or longer. Occasionally a small incision to drain the swelling is required.
- ___ Restricted mouth opening (trismus), jaw muscle spasm, jaw muscle cramps, temporomandibular joint difficulty or change in bite. This occurs infrequently and usually lasts for several days, but may last longer.
- ___ Failure rate of 5-10% under optimal conditions. If failure occurs, additional treatment will be required such as retreatment, endodontic surgery or extraction of the affected tooth. Retreatment (of previously unsuccessful endodontic therapy) failure rates are higher, but vary due to suspected reason for failure.

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___ With some teeth conventional endodontic (root canal) therapy alone may not be sufficient. Thus, in some cases additional treatment may be required.

For example:

- a) If the canal(s) are severely bent, calcified/blocked, or split such that they cannot be treated.
- b) If an endodontic instrument separates (breaks) in the tooth during treatment.
- c) Periodontal disease or problem in which periodontal treatment may be needed.
- d) Preexisting fractures, substantial infection in the bone, or perforation of the root, tooth or sinus.

In some cases, follow-up visits may be recommended while in others an endodontic surgical procedure, extraction, or other treatment may be required to resolve the problem. The doctor will explain the options available.

___ Restoration damage such as porcelain fracture while preparing an opening in the restoration or removing restoration for access to the root canals. If damage occurs, many may be "patched" while others may require replacement of the restoration. Occasionally a restoration may be loosened.

___ Premature tooth loss due to progressive periodontal (gum) disease and/or loosening of the tooth.

___ Complications resulting from use of instruments, materials, medications, anesthetics, and injections.

I understand that after endodontic therapy, my tooth may require additional restoration (filling, onlay crown, or bridge). I realize that should I neglect to return to my restorative (family) dentist for the proper restoration, there is an increased risk for:

- 1) failure of the endodontic therapy,
- 2) fracture of tooth and/or
- 3) premature loss of tooth.

I understand that I am to return to this office periodically for a re-evaluation visit, usually every 6-12 months for at least 2 years. The purpose of this visit is to monitor the endodontic treatment for healing and to recommend further treatment as may be needed. If I do nothing, pain, severe abscess or disabling infection can result. Teeth treated with endodontic therapy can still decay. As with other teeth, the proper care of these teeth consists of good home care, sensible diet, and periodic check-ups.

No guarantee of success or perfect result has been given to me. I understand the proposed treatment may not be curative and/or successful to my complete satisfaction. The diagnosis, method and manner of the proposed procedure(s), the nature and purpose, prognosis, risks of treatment and feasible alternatives have been explained to me. I consent to endodontic (root canal) therapy and the administration of local anesthetic.

I fully understand this consent form and that it does not encompass the entire discussion regarding the proposed treatment I had with the doctor. I have had the opportunity to question the doctor concerning the nature of treatment, the inherent risks of treatment and the alternatives to this treatment.

Patient (or Legal Guardian) _____ Date _____