



BOONE ENDODONTICS

INFORMED CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Please **initial** each item. Let Dr. Homa Azargoon know if you have questions **BEFORE** initialing.

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Success rates for root canal treatment are 85-98% based on the scientific literature. Root canal therapy is a dental-biological procedure and success is not guaranteed. It is important that you understand and accept potential complications that may occur during treatment and may affect the outcome of the treatment. Such complications include, but are not limited to the following:

_____ Post-operative discomfort or sensitivity lasting a few hours to several days that may require pain-relieving medications as deemed necessary by the dentist.

_____ Post-operative swelling of the surrounding gum tissues or face that may require antibiotics as deemed necessary by the dentist.

_____ Exacerbation or creation of restrictive mouth opening (TMJ, TMD, jaw muscle spasms, jaw muscle cramps) due to the length of time required to maintain an open mouth during root canal treatment procedures.

_____ Complications associated with anesthetics, chemicals or medications such as allergic reaction, fainting, heart palpitations, overdose, bruising, numbness and hematoma, which may last for days/weeks/months/permanently.

_____ Separation (breakage) of instruments in the canal that may, at the judgment of the dentist be left in the canal or require surgery.

_____ Perforation of the tooth/root, which may require additional surgical treatment by a specialist or result in the loss of the tooth.

_____ Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.

_____ Irreversible damage of the tooth/restoration (especially porcelain restorations) during treatment that may require a new restoration and/or possibly loss of the tooth. Permanent crowns may come off during treatment and require replacement.

_____ Complications associated with past or current use of bisphosphonate therapies (i.e. Fosamax, Boniva), which may impact surgical or non-surgical endodontic treatment.

_____ I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

_____ I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease problems.

_____ I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me.

_____ Following the completion of root canal therapy, it is crucial that you return to your dentist for definitive restoration of the treated tooth. A **temporary** restoration is included in the root canal therapy fee. It may be possible have a **permanent** restoration placed in our office for an additional fee. The placement of a **permanent** restoration should be done no later than **4 weeks**, unless you continue to have symptoms. If this occurs, please contact our office for further evaluation. Failure to complete this important phase of treatment may result in recontamination of the root canal system. This may lead to the need for retreatment, surgery, or result in loss of the treated tooth.

_____ I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to have all of my questions answered.

A follow up evaluation in 12 months is needed. This is considered a part of the therapy and there is no fee for this service.

Signature of patient, parent or guardian

Date

Witness Signature

Date