Informed Consent for Root Canal Treatment

Name: _____ DOB: _____ Case #: _____

I hereby authorize the doctor and any associates to treat the condition described below (diagnosis):

_____

and to perform a root canal on tooth/teeth number(s):

_____

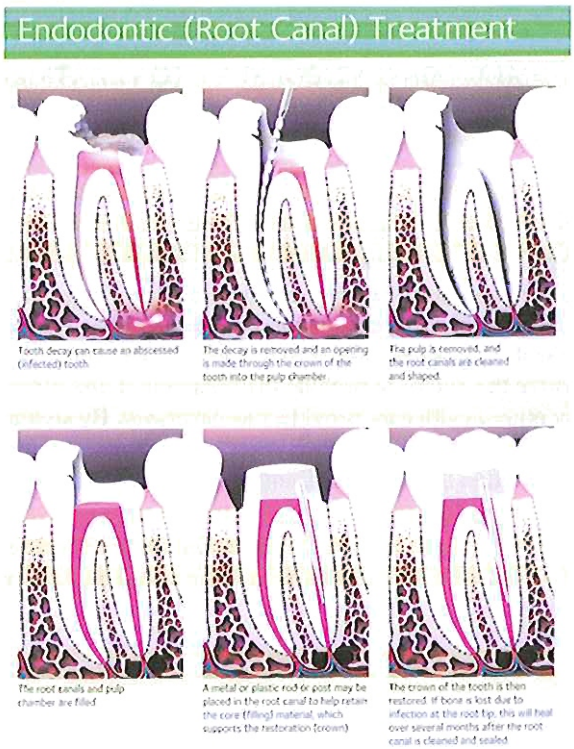
I understand the following treatment alternatives:

_____

The prognosis for this procedure is as follows:

_____

- ☐ The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatments, and the doctor has explained the risks and benefits of the alternatives including no treatment at all. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result.
- ☐ The doctor has explained to me that there are certain potential risks in the procedure. These include, but are not limited to:
  - ☐ Inability to completely fill the root canal because the canal is calcified or has a unique curvature. This may require endodontic surgery or extraction of the tooth.
  - ☐ Infection/swelling/bleeding that may occur and may continue, requiring further interventional therapy, such as endodontic surgery or extraction.
  - ☐ Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this can persist for several weeks, months or, in rare instances, permanently
  - ☐ Fracture or breakage of the root or crown portion during or after treatment.
  - ☐ Changes in the bite (tooth occlusion), jaw/facial muscle spasm, jaw joint (TMJ) instability (clicking)
  - ☐ Referred pain to neighboring anatomical areas of ear, eye, neck, shoulder, etc.
  - ☐ Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved.
  - ☐ Perforation of the tooth during treatment.
  - ☐ Damage to existing teeth, fillings, crowns, or porcelain veneers.
  - ☐ Other: _____



- ☐ It has been explained to me that during the course of the procedure(s), unforeseen conditions may be revealed that may necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I, therefore, authorize and request that the doctor and any associates perform such procedures as are medically necessary and desirable in the exercise of their professional judgment. The authority granted under this provision shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.
- ☐ I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described above, and to the use of such anesthetics as may be advisable with the exception of my allergy to _____. I recognize that there are always risks to life and health associated with anesthesia and such risks have been fully explained to me.

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☐ Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile, or hazardous devices or to work, while taking such medications and/or drugs, or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that I may have been given in the office for my care. Unusual reaction to medications given or prescribed, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during the active treatment period.

Please do not hesitate to ask the doctor or the staff if you have any questions.

OFFICE AGREEMENTS: I agree to follow the doctor's directives ***precisely*** and ***completely*** throughout my course of therapy. Following directions ***exactly*** ensures optimal care and maximizes my potential for improved health. I agree to keep regularly scheduled appointments as directed by the doctor in order to maintain continuity of care. I agree to pay for services rendered as outlined in the financial agreement. I agree to conform to acceptable, peaceful behavior during my course of therapy at this office. I agree to be honest and forthright with all interactions and communications and have not misrepresented myself in patient registration information and health history matters. A breach of any of these agreements terminates the doctor/patient relationship as defined by this document.

CONSENT TO USE OF RECORDS/DUPLICATE RECORD REQUESTS: I hereby give my permission for the use of records, including photographs, before, during, and after treatment for purposes of professional consultations, research, education, or publication in professional journals. Duplication of records for other health care providers ***requires*** that a HIPAA Authorization Form be completed and signed, and submitted with the appropriate fees for record duplication.

INFORMED CONSENT/CONSENT TO TREATMENT:
I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the doctor and have been given the opportunity to ask any questions and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered, though no guarantees have been made regarding the outcome. I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me, and I accept them as satisfactory. I understand that my treatment fee covers only treatment provided by this office, and that treatment provided by other dental or medical professionals is not included in the fee for my treatment. I have been asked to make a choice about my health and treatment. I hereby consent to the treatment proposed and authorize the doctor to provide the treatment. I also authorize the doctor and/or all associates to provide my health care information to my other health care providers as necessary. By signing this form, I am freely giving my consent to authorize the doctor and/or all associates involved in either rendering services or treatment necessary to improve the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

Good communication is essential to achieve optimal treatment results.
Please call the office if you have any questions or problems regarding treatment.

_____ _____
Date **Patient or Legal Guardian Signature**

_____ _____
Witness **Printed Name**

_____
Doctor Signature

☐ **Informed Refusal**: I decline the treatment as outlined above and accept full responsibility for the consequences of these actions.
Initials: _____

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