San Clemente Endodontics

PRELIMINARY CONSENT AND INFORMATION FORM

Regarding Health History, Endodontic (Root Canal) Therapy, Premedication, Local Anesthetic and Medication

It is the belief of this office that you should be informed about the treatment (therapy) and that you should give your consent before starting that treatment. The purpose of this form is to inform you of the risks that MAY occur in the endodontic (root canal) treatment, and other treatment choices.

Root canal treatment is performed in order to retain a tooth (or teeth) which otherwise might need to be removed. Related dental surgery is performed when needed.

There are two types of risks of treatment: (1) those risks involved in general dental procedures, and (2) those risks specific to endodontic treatment.

RISKS OF DENTAL PROCEDURES IN GENERAL include, but are not limited to, complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. Such potential complications include pain, infection or infection spreading to other areas; swelling, bleeding and sensitivity; numbness and tingling sensations (temporary or permanent) in the lip, tongue, chin, gums, cheeks and teeth; thrombophlebitis (inflammation to a vein); adverse reactions to injections; change in occlusion (biting); jaw muscle cramps and spasms, temporo-mandibular (jaw) joint difficulty; loosening of teeth or restorations in teeth; injury to other tissues; referred pain to the ear, neck and head; nausea and vomiting; allergic reactions and itching; bruises, delayed healing, sinus complications, perforations and further surgery.

Medication and drugs may additionally cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects. Please note that antibiotics may inhibit the effectiveness of birth control pills you are taking.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY include instruments broken within the root canals; perforations (extra openings) of the crown and root of the tooth or sinus; facial discoloration; damage to bridges, existing fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to canals; cracked teeth and treatment failure. During treatment, complications may be discovered which make treatment impossible, or which may require a dental surgery. These complications may include: blocked canals due to fillings; prior treatment on the tooth; naturally occurring calcification; unusual tooth anatomy; curved roots; periodontal disease (gum disease/pyorrhea); broken instruments left in tooth; complications from use of medication, anesthetics and injections; and splits or fractures of the teeth. Success cannot be guaranteed.

OTHER TREATMENT CHOICES INCLUDE no treatment; waiting for more definite development of symptoms; having the tooth removed; obtaining a second opinion. Risks involved in these choices might include increased pain, swelling, infection, loss of tooth, and infection spread to other areas.

I understand that upon my request, I may receive a copy of this form. I also understand that upon completion of treatment in this office, I will be directed to return to my general dentist for permanent restoration such as a crown, cap, jacket, onlay, or filling. I, the undersigned patient (parent or guardian of minor patient) consent to the performing of the procedures decided to be necessary or advisable in the opinion of the doctor.

Root canal treatment is an attempt to retain a tooth, which may otherwise require extraction. **ALTHOUGH ROOT CANAL THERAPY HAS A HIGH DEGREE OF SUCCESS, IT CANNOT BE GUARANTEED OR WARRANTED**. Occasionally a tooth previously treated may require retreatment, surgery or even extraction. **San Clemente Endodontics makes no express or implied warranties with regard to the success of any procedure.**

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT

PATIENT, PARENT, AGENT	**DATE**	**TIME**	**WITNESS**