American Association of Endodontics
Specialists Member

D. K. FAGUNDES
ENDODONTICS

Diplomate of the American Board of Endodontics
105 Parker Drive ● LaGrange, Georgia 30240

Name: ____

CONSENT TO ENDODONTIC THERAPY

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

Risks: The risks include the possibility of instruments broken within the root canals; perforations (extra opening) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require dental surgery. These complications may include: swelling, pain, restricted jaw opening, infection, bleeding, sinus involvement and numbness and tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand it is my responsibility to report any symptoms to the endodontist immediately.

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Birth control pills are not effective when taking antibiotics. You further understand that certain medications may cause hives and intestinal problems and if any of the above reactions occur, you are to call the endodontist immediately.

Other Treatment Choices: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

Consent: I, the undersigned, being the patient (parent or guardian of above minor patient), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that, upon completion of root canal therapy in this office, I should return to my general family dentist for a permanent restoration (such as a crown, cap, or other permanent filling) of the tooth involved. I give permission for taking video, x-ray and photographic images of my mouth and teeth for teaching and educational purposes.

I understand that root canal treatment is an attempt to save a tooth which may other-wise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

______________________________ Signature of Witness

______________________________ Signature of Patient/Parent or Guardian

- -

PLEASE DO NOT WRITE IN THE SPACE BELOW UNTIL YOU HAVE TALKED TO THE DOCTOR

Name: ____

____

Procedure	Date	Doctor	Assistant

If there is anything you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form and talking to the doctor, please write your questions below or write “NONE” below:

____