

ROOT CANAL TREATMENT

A root canal is a dental treatment to repair and save a tooth that is badly decayed or infected. It is a treatment of the pulp of the tooth. The pulp is a soft substance in the center of the tooth that consists of nerve, blood vessels, and connective tissue. The tooth's nerve lies within root canals, which lie within the roots, or "legs," of the tooth.

Root canal treatment may require multiple visits. It is important that patients return to our office after the procedure for follow-up to ensure that treatment is proceeding successfully.

Patient's
Initials

_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

_____ My mouth has been carefully examined. Alternative methods and therapies and their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of

_____ are not limited to:

(Procedure Name)

___ Pain

___ Bruising

___ Swelling

___ Infection

___ Numbness of the lip, tongue, chin,
cheek(s), or teeth

___ Sinus penetration

___ Bone fractures

___ Delayed healing

___ Potential soft tissue surgery

___ Visible implant injury to teeth

___ Failure of implant, resulting in need for
removal or possible bone loss

_____ I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, infection, sensitivity, looseness, or drifting teeth followed by necessity of extraction.

_____ I understand and accept that complications, including the remote risk of death or serious disability, exist with any surgical procedure.

_____ I request and authorize dental services, including root canal treatment and other surgery.

_____ I fully understand that during and following the contemplated dental procedure, oral surgery, or treatment, conditions may become apparent that warrant, in the judgment of my dentist/oral surgeon, additional or alternative treatment pertinent to a successful outcome. I also approve any modifications in design, materials, or care if it is felt by my dentist to be in my best interest.

_____ I am aware that occasionally speech can be affected by oral surgery/dental procedures. I am aware that further soft tissue surgery is sometimes necessary to improve the final outcome.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications (if applicable).

_____ I understand that excessive smoking or use of alcohol or sugar may affect gum healing and may limit the success of my procedure. I agree to follow my doctor's home care instructions and to report to my dentist for regular examinations as instructed.

- _____ I understand that oral hygiene is critical to the future success of my treatment plan and that I must maintain good oral hygiene. Like normal dentition, the desired outcome of this procedure may be affected by lack of oral hygiene and can actually be lost due to neglect.
- _____ I have informed the dentist of all my known allergies.
- _____ I have informed the dentist of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- _____ To my knowledge, I have given an accurate report of my physical and mental health history, including any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, or dust, and any abnormal bleeding or other condition.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ I have been informed of what to expect postoperatively, including but not limited to, estimated recovery time, anticipated activity level, and the possibility of additional procedures.
- _____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation (if applicable).
- _____ Pre- and postoperative photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending dentist/oral surgeon (if applicable).
- _____ I agree to the type of anesthesia—local or general—administered intravenously, intramuscularly, orally, or by inhalation. I agree not to operate a motor vehicle or machinery for at least 24 hours (or more) until I am fully recovered from the effects of anesthesia or medications given for my care. I am aware that possible anesthesia risks include inflammation of veins and allergic reactions caused by my medications.
- _____ I am satisfied that the dentist has answered all of my questions regarding this procedure and that I understand all the terms of this agreement.
- _____ ***During the Procedure:*** An average of six to eight x-rays (occasionally more) will be taken to determine the length of the files and filling materials within the roots. Endodontic treatment cannot be performed without these x-rays. Many patients express concern about x-rays. While the desire to keep radiation exposure to a minimum is understandable, please be aware that, with modern equipment, the exposure from dental x-rays is minimal and poses no health risk.
- _____ ***After the Treatment:*** Following root canal treatment, you must have your dentist place a permanent restoration on the tooth—usually a crown. Failure to have a permanent restoration placed within six weeks following root canal treatment may result in leakage of the temporary restoration and reinfection of the root canals (requiring retreatment of the root canal) or a fracture of the tooth (often requiring extraction).

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, DDS/DMD/MD, with associates or assistants of his or
her choice, to perform the procedure of _____ on
_____ at _____
_____ on the _____.
(Dentist Name) *(Procedure Name)*
(Patient Name) *(Facility Name)*
(Tooth Number)

I further authorize the dentist(s)/oral surgeon(s) and any assistants to perform any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time *Relationship to Patient*

Print Patient or Legal Representative Name *Witness Signature/Date/Time*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe the patient/legal representative (*circle one*) fully understands what I have explained.

Dentist Signature/Date/Time

Initials Copy given to patient

Initials Original placed in patient's chart