LONDON DENTAL CARE

Mark M. Lima, DDS, LLC
116 E. High Street, London, Ohio 43140
(740) 852-5771

ENDODONTIC CONSENT TO TREATMENT FORM

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 the possible risks that may occur from endodontic treatment and other treatment choices.

GENERAL RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and infections. These complications include: swelling, sensitivity; bleeding; pain; infection; numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; reaction to infections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing, sinus perforation and treatment failure.

RISK MORE SPECIFIC TO ENDODONTIC THERAPY: The risk include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or the 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; blocked canals due to filling or prior treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, splits or fractures of the teeth, over-extension of root canal filling material.

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). I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care as selected by my doctor.

OTHER TREATMENT CHOICES: The doctor has informed me of alternative choices that include but are not limited to: not treatment, waiting for more definite development of symptoms, tooth extraction. The doctor has informed me that the risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

CLINICAL HISTORY: To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions relating to my health or any problems experienced with any prior medical, dental or other healthcare treatment.

CONSENT: I, the undersigned, being the patient and/or parent or guardian of the above 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 a permanent restoration of the tooth involved, such as a crown, cap, jacket or onlay will be necessary. I understand that root canal treatment is attempted to save the tooth which may otherwise require extraction. Although root canal therapy has a very high degree of success, it cannot be guaranteed. Occasionally a tooth which has had canal therapy may require additional treatment, surgery or even extraction.

TOOTH NUMBER_____ DATE: _____

_____ _____

Signature of patient and/or parent or legal guardian **Signature of treating doctor**