WESTSIDE ENDODONTICS
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PATIENT CONSENT
for Endodontic Treatment

A. Steven Singh DDS

Please read and initial the following important information regarding your endodontic treatment.

1. ____ I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, many factors contribute to it's success or failure, which may not be determined in advance. Therefore, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Some of these factors include, but are not limited to: resistance to infection, the shape and location of the root anatomy, periodontal (gum) disease, a tooth fracture that either was undetectable or occurred after the treatment, failure to keep scheduled appointments, or the failure to have the tooth restored promptly after completion of the treatment.

2. ____ I understand the complications of endodontic therapy may include, but are not limited to: the possibility of instruments separating within the root canals, perforations (extra opening) of the crown or root of the tooth, damage to existing fillings, crowns or bridges, fracture of the tooth, discomfort, jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, swelling and pain. During the treatment, complications may be discovered which make treatment impossible or which may require endodontic surgery or extraction of the tooth.

3. ____ I understand that complications of anesthesia, injections, prescribed pain relievers and other medicines. This may include, but are not limited to: swelling, infection, bleeding, discoloration of the face, discomfort, pain, nausea, drowsiness, allergic reactions, numbness or tingling of the lip, gum or tongue (this condition is usually temporary).

4. ____ I have been informed of possible alternative treatment methods, including extraction or no treatment at all.

5. ____ I have been given the opportunity to ask questions and have answered questions regarding my treatment. At this time, I have questions regarding:_____

6. ____ I understand that I must return to my referring doctor for placement of the final restoration as early as possible to prevent failure of the root canal treatment and/or fracture of the tooth.

For patients requiring SURGERY ONLY:

7. ____ I have been informed of my pre-existing condition:_____

8. ____ The recommended treatment is:_____

9. ____ I have been informed of all the risks, including potential extraction of the tooth if determined to be necessary. At this time, I have questions regarding:_____

10. ____ I understand the importance in keeping follow-up appointment to promote the success of treatment.

ALL PATIENTS MUST SIGN BELOW

I have filled out the Health History form, and give consent for Endodontic treatment.

Patient Signature:_____

Thank you!