SANTA CLARA ENDODONTICS

INFORMED CONSENT DISCUSSION FOR ROOT CANAL TREATMENT

Patient Name: _____ Patient SSN: _____

Diagnosis: _____

FACTS FOR CONSIDERATION

Patient's initials required

_____ Root canal treatment, also called *endodontic treatment* involves removing the nerve tissue (called *pulp*) located in the center of the tooth and its root or roots (called the root canal). Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp, which then are removed. Medications may be used to sterilize the interior of the tooth to prevent further infection. Root canal treatment may relieve symptoms such as pain and discomfort.

_____ Twisted, curved, accessory or blocked canals may prevent removal of all inflamed or infected pulp. Since leaving any pulp in the root canal may cause your symptoms to continue or worsen, this might require an additional procedure called an *apicoectomy*. Through a small opening cut in the gum and surrounding bone, any infected tissue is removed and the root canal is sealed. An apicoectomy may also be required if your symptoms continue and the tooth does not heal. Apicoectomy will be done by an Oral Surgeon.

_____ Once the root canal treatment is completed, it is essential to return promptly to begin the next step in treatment. Because a temporary seal is designed to last only a short time, failing to return as directed to have the tooth sealed permanently with a crown or filling can lead to other problems such as deterioration of the seal, resulting in decay, infection, gum disease, fracture and the possible premature loss of the tooth.

BENEFITS OF ROOT CANAL TREATMENT, NOT LIMITED TO THE FOLLOWING:

_____ Root canal treatment is intended to allow you to keep your tooth for a longer time, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment has been recommended to relieve the symptoms of the diagnosis described above.

RISKS OF ROOT CANAL TREATMENT, NOT LIMITED TO THE FOLLOWING:

_____ I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible infection may accompany root canal treatment and must be treated with antibiotics. I will immediately contact the office if conditions worsen or I experience fever, chills, sweats or numbness.

_____ I understand that I may receive a local anesthetic and/or other medication. In rare instances patients have a reaction to the anesthetic, which may require medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

_____ I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking, which are listed on my patient history form.

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. I must notify your Office if this or other concerns arise.

_____ I understand that occasionally a root canal instrument may break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment may be retrieved or it may be necessary to seal it in the root canal (these instuments are made of sterile, non toxic surgical stainless steel, so this usually causes no harm). It may also be necessary to perform an apicoectomy, as descibed above, to seal the root canal.

_____ I understand that during treatment the root canal filling material may extrude out of the root canal into the surrounding bone and tissue. Occasionally, an apicoectomy may be necessary for retrieving the filling material and sealing the root canal.

_____ I understand teeth that receive root canal treatment may be more prone to cracking and breaking over time, may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal treatment may not relieve all symptoms. The presence of gum disease (*periodontal disease*) can increase the chance of losing a tooth even though root canal treatment was successful.

_____ I understand that root canal treatment may not relieve my symptoms, and I may need my tooth extracted.

Consequences if No Root Canal Treatment Is Administered, Not Limited to the Following:

_____ I understand that if I do not have root canal treatment, my discomfort may continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually, the loss of my tooth and/or adjacent teeth.

Alternative Treatments if Root Canal Treatment Is Not the Only Solution, Not Limited to the Following:

_____ I understand that depending on my diagnosis, alternatives to root canal treatment may exist which involve other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an *implant*. I have asked my dentist about the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures, their risks, benefits, and costs. Alternatives discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the conditions listed above.

- ☐ I consent to the root canal treatment as described above by Dr. Jespersen / Dr. Photopoulos.
- ☐ I refuse to give my consent for the proposed treatment as described above.
- ☐ I have been informed of and accept the consequences if no treatment is administered.

Patient's Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives to root canal with _____ (patient's name) who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Dentist's Signature Date

Witness Signature Date