Artistic Dentistry of Atlanta

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INFORMED CONSTENT FOR ROOT CANAL TREATMENT

TOOTH/TEETH NUMBERS_____

I have been made aware of my condition of tooth/teeth requiring endodontic (root canal) treatment in the opinion of my dentist. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic diseases problems.

Some complications of root canal treatment may be, but are not limited to:

A. Failure of the procedure necessitation re-treatment, root surgery, or extraction.
B. Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer.
C. Breakage of an instrument inside the canal during treatment, which may be left as it, or may require surgical removal.
D. Perforation of the canal with instruments which may require additional surgical treatment or result in the loss of the tooth.
E. Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of lip, chin, tongue, or other areas.

Some of these complications may require additional surgical treatment by a specialist and the cost of which is my responsibility. Successful completion of the root canal procedure does not prevent future decay or fracture.

I understand that in order to achieve the most optimal and predictable results, I need to complete the entire root canal procedure, which may take more than two visits. If I do not complete the entire root canal procedure within the amount of time that my dentist has recommended, I understand that the root canal may fail, and the tooth needs to be re-treated or extracted.

An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown with build-up is recommended after treatment to lessen the chances of fracture.

I understand the recommended treatment, the risks of such treatment, any alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me, and I have had a chance to have all of my questions answered.

I understand it is my responsibility to notify this office should any undue or unexpectedproblems occur or if I experience any problems relating to the treatment rendered or the servicesperformed.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding thenature and purpose of root canal treatment and have received answers to my satisfaction. I do voluntarilyassume any and all possible risks, including risks of substantial harm, if any, which may be associatedwith any phase of this treatment in hopes of obtaining the desired and/or any satisfactory results. Bysigning this form, I am freely giving my consent to authorize Dr. Peter Vanstrom and/or Dr. Anna Refaiin rendering any services he/she deems necessary or advisable totreatment of my dental conditions, including the administration and/or prescribing of any anestheticand/or medications.

Patient (Printed name) Date

Patient Signature

Relationship to patient if not the patient:

Witness Date

Doctor Date