

Charter Oak Endodontics, Inc.
Endodontic Treatment Consent and Information Form

The purpose of this office is to provide quality care for our patients. Root canal therapy is performed to treat a tooth that might otherwise need to be extracted. Sometimes, root canal therapy may need additional management, such as retreatment or surgery. The fee quoted is for the current endodontic (root canal) therapy only; and not for the final restoration (filing, crown, etc.) nor any future treatment or surgery that may become necessary. _____

I understand certain risks are associated with these treatments, as in all areas of dentistry. Complications may result from the use of dental instruments, drugs, and anesthetics. These may include, but are not limited to: swelling; sensitivity; bleeding; pain; infection; numbness which usually lasts for a few hours but may be permanent; reaction to shots; changes in biting and the way teeth fit together; muscle cramps; joint difficulties; loosening of teeth; damage to other teeth including other restorations; pain to the ear, neck, and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failures. During the instrumentation of the tooth, a procedural error may occur. Although this occurs rarely, such an occurrence could cause the failure of the root canal, loss of the tooth, or possibly the need for a new crown or restoration. _____

I understand that I may have to take certain medications (drugs) while this therapy is being performed which may result in allergic reactions, drowsiness or lack of awareness and coordination. I understand that I am not to use alcohol, tranquilizers, or sedatives while on medication for my treatment unless otherwise instructed by my doctor. I understand that I am not to drive or operate a car, or other machines, while taking certain medications as indicated by my doctor. _____

I understand that other treatment choices include no treatment or extraction of my tooth. Risks of these choices include, but are not limited to pain, swelling, loss of teeth, and/ or infection to other area of the body (same as those listed previously). _____

Temporary fillings are usually placed in the tooth after root canal treatment. I understand that upon completion of the root canal therapy, it is my responsibility to have a final restoration (filling, crown, etc.) place on the endodontically treated tooth. Future decay or fracture is possible; therefore, regular cleanings and dental checkups are advised. If you do not receive your general dental care at Dickson Dental, a referral will be provided. _____

Any and all of my questions have been clearly answered. I also understand that any questions that I might have during the treatment will be answered when I ask them. I, the undersigned, being the patient (parent or guardian of a minor patient) consent to endodontic therapy on the involved tooth (or teeth). I have read this form. _____

Tooth # _____

Endodontic Fee \$ _____

Date

Patient/Guardian Signature

Doctor Signature

Witness
