Broken Arrow Endodontics
CONSENT FOR ENDODONTIC THERAPY

"WELCOME TO OUR OFFICE" Consent form has been received and understood. I understand that upon my request I may receive a copy of this form. I also understand that upon completion of root canal therapy in this office I will be directed to return to my general family dentist for permanent restoration such as a crown, cap, or filling. I, the undersigned, being the patient (parent or guardian of minor child) consent to the performing of the procedures decided upon after consultation to be necessary or advisable in the opinion of Dr. J. Michael Strand D.D.S.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting),muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty four hours or until recovered from their effects.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: These risks include instruments broken within the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns and 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 fillings, prior treatment, natural calcification, broken instruments, curved roots, infection, swelling, periodontal disease (gum disease/pyorrhea), splits or fractures of the teeth. Clothing may be damaged during procedure, due to the bleach like irrigation used to disinfect the canal space.

THE OTHER TREATMENT CHOICES include: No treatment, waiting for more definite development of symptoms or having the tooth removed. Risks involved in these choices might include pain, swelling, infection, loss of tooth, and infection to other areas. Treatment will be done in a manner to minimize or avoid risks as success cannot be guaranteed.

I understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success (80%-95%), it cannot be guaranteed. Occasionally a tooth which has had a root canal may require retreatment, surgery or even extraction.

Treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and the placement of a rubber dam. In addition, a number of radiographs will be necessary to accomplish the root canal procedure. The number of radiographs will vary with the complexity of the case.

The number of treatment visits required to complete the root canal varies with the complexity of each case. Generally, the routine cases can be completed in a single visit.

If at any time I have any questions about the treatment I am receiving, they will be promptly answered.

I understand that I am free to withdraw my consent and discontinue treatment at any time; however, complications, such as bone destruction, infection, and swelling may predictably occur if the root canal treatment is not completed.

By signing this release, I also allow the release of treatment information, photographs and/or radiographs (x-rays) to be used for teaching purposes, or for publication. Personal identification or information will be kept confidential.

Dr. Strand will perform an examination and evaluation for treatment, discuss treatment plans, fees and answer all of your questions before any treatment will be started.

Patient/Parent Signature:_____ Date:_____

Signature of Witness:_____