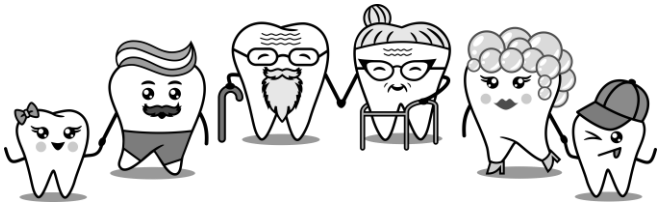
Dr Ivana Bugwandeen Inc



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Discussion and Consent for Root Canal Treatment

Patient's Name:

_____	_____	_____	_____
Last	**First**	**Initial**	**Date of Birth:**

I am being provided with this information and consent form so I may better understand the treatment recommended for me.
Before beginning, I wish to be provided with sufficient information, in a way I can understand, to make a well informed decision regarding my proposed treatment.
I understand that I may ask any questions I wish, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Endodontic Treatment

Root canal treatment has been recommended for me on the following tooth (teeth): _____
Following root canal treatment, the tooth will need a final restoration, usually a crown, to return it to proper function. The final restoration is part of this discussion and consent.
Root canal treatment is necessary because of:
☐ Pain ☐ Infection ☐ Decay ☐ Broken Tooth/Teeth ☐ Other: _____

The intended benefit of root canal treatment is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed. Root canal treatment also retains the tooth root in my mouth, permitting the tooth to be restored to proper function.

The prognosis or likelihood of success, of this root canal treatment is _____

My **root canal treatment** is estimated to cost R_____ and is estimated to take

_____visit(s) to complete.

Risks of Endodontic Treatment

I have been informed and fully understand that there are certain inherent and potential risks associated with root canal treatment.
I understand that during and after treatment I may experience pain or discomfort, swelling, bleeding, changes in my bite, and loosening or loss of dental restorations. I understand that it is possible for an infection to occur or an existing infection to worsen in the tooth being treated and/or in the area around the tooth, and that I may need antibiotics and/or other procedures to treat the infection.
I understand that root canal instruments sometimes separate (break) inside the canal. This is more likely when canals are curved and/or narrowed. If the separated fragment cannot be retrieved, it may require sealing inside the root canal. It also may be necessary to have oral surgery performed on the tooth root (apicectomy) to address the problem. I understand that a separated instrument often decreases the likelihood of clinical success.

I understand that other risks include: perforation of the tooth or tooth root by an instrument; injury to soft tissues adjacent to the tooth; sinus perforation; Nickel Titanium allergies and nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance, if ever.

I understand that once root canal treatment is completed, I must promptly return to begin the next step in treatment. If I fail to return to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth.

Other foreseeable risks not stated above include:_____

☐ Initial

I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including _____

Acknowledgment

I _____have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended root canal treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options (such as extraction), the risks of the recommended treatment, and the risks of refusing treatment.
I wish to proceed with the recommended treatment.

☐ Initial

I understand this treatment can also be performed by an endodontist (a root canal practitioner). I understand the risks and elect to have this procedure performed by Dr._____
I understand that if any unexpected difficulties occur during treatment, I may be referred to an endodontist for further care.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness