Endodontic (Root Canal)
Informed Consent

- The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted. However, it is a biological procedure and results cannot be guaranteed.
- Occasionally, and despite our best efforts, a tooth that has undergone root canal therapy may require re-treatment, root canal surgery or extraction.
- We make special efforts to preserve the crown/bridge of teeth we treat, but despite our best efforts occasionally a crown/bridge may fracture or come off and require a new restoration.
- It is important for Dr. Osmond to have accurate and complete medical information to prevent unnecessary complications during your treatment.
- Treatment may require multiple visits. It is important that you maintain scheduled appointments or the infection may reoccur.
- If any unforeseen condition arises in the course of treatment, you authorize Dr. Osmond, in his judgment, to perform different or additional procedures from those now contemplated.
- The most common potential risks include, but are not limited to:
  Swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm; tempromandibular joint (TMJ) difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments - perforation of tooth, root or sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and **antibiotics may inhibit the effectiveness of birth control pills.**
- In most cases, there is only mild discomfort following each treatment. This is usually controlled with ibuprofen, Tylenol, aspirin or prescribed medication.
- Final restoration of the tooth that has undergone root canal therapy is essential for retention of the tooth. **A final restoration (crown) should be completed within 30 days of root canal therapy.**

I authorize Dr. Osmond and staff to treat tooth #_____ , due to endodontic disease, by:

- ○ Root canal treatment
- ○ Root canal retreatment
- ○ Periapical surgery
- ○ Other _____

By signing below, I have read and understand this form and have had all my questions answered.

_____ _____

Patient/Guardian Signature ***Date***