NEW TOWN DENTAL

INFORMED CONSENT
ROOT CANAL TREATMENT

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatments and the doctor has explained the risks and benefits of the alternatives. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result. The doctor has explained to me that there are certain potential risks in the procedure. These include:

1. Inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth)

2. Infection that may occur and may continue, requiring further endodontic surgery or extraction

3. Fracture or breakage of the root or crown portion during or after treatment

4. Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved

5. Perforation of the tooth or root of the tooth during treatment

6. Damage to existing fillings, crowns or porcelain veneers

7. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues

8. Other:_____

Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain).

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

ALTERNATIVES TO ENDODONTIC TREATMENT:
Depending on my diagnosis, there may or may not be alternatives to root canal treatment that involve other types of dental care.
I understand the two most common alternatives to root canal treatment are:
• Extraction. I may decide to have the tooth removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
• No treatment. I may decide not to have any treatment performed at all. If I decide upon not having the recommended treatment, my condition may worsen and I may risk serious personal injury, including severe pain; localized infection; loss of this tooth and possibly other teeth; severe swelling; and/or severe infection that may be potentially fatal.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of the root canal treatment and have received answers to my satisfaction. I voluntarily assume any and all known possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are acceptable.
By signing this form, I am freely giving my consent to allow and authorize
Dr. Snydman and/or his associates to render any treatment necessary or advisable for my dental conditions, including any and all anesthetics and/or medications.

_____I understand this treatment can also be performed by an endodontist (a root canal specialist).
Patients Initials

Tooth Number(s):_____

_____
Patients Name (please print)

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Signature of Treating Dentist Date

_____ _____
Witness to signature Date