Crown Dental Studio

INFORMED CONSENT FOR ENDODONTIC TREATMENT

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, as with all medical and dental procedures, it is a procedure whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally an unapparent, undiagnosed or hidden problem arises.

This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had root canal treatment may require re-treatment, endodontic surgery, or tooth extraction.

Risks: *Are unlikely, but may occur. They might include but are not limited to:*

1. Instrument separation in the canal.
2. Perforations (extra openings) of the canal with instruments.
3. Blocked root canals that cannot be ideally completed.
4. Incomplete healing.
5. Post-operative infection requiring additional treatment or the use of antibiotics.
6. Tooth and/or root fracture that may require extraction.
7. Fracture, chipping, or loosening of existing tooth or crown.
8. Post-treatment discomfort.
9. Temporary or permanent numbness.
10. Change in the bite or jaw joint difficulty (TMJ problems or TMD).
11. Medical problems may occur if I do not have the root canal completed.
12. Reactions to anaesthetics, chemicals or medications.

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Other Treatment Choices:

The following other treatment options might be possible:

1. No treatment at all.
2. Waiting for more definitive development of symptoms.
3. Extraction: To be replaced with either nothing, a denture, a bridge or an implant.

After the completion of the root canal procedure, you will be referred for the permanent restoration (filling, crown, cap). Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture.

I UNDERSTAND THAT TREATMENT OF DENTAL CONDITIONS INCLUDES CERTAIN RISKS AND POSSIBLE UNSUCCESSFUL RESULTS, INCLUDING THE POSSIBILITY OF FAILURE. NO PROMISES OR GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE PROGRESSION OR RESULTS OF THE TREATMENT. BY SIGNING THIS FORM, I AM FREELY GIVING MY CONSENT TO ALLOW AND AUTHORIZE CROWN DENTAL AND/OR THEIR ASSOCIATES TO RENDER ANY TREATMENT NECESSARY OR ADVISABLE TO MY DENTAL CONDITIONS, INCLUDING ANY AND ALL ANAESTHETICS AND/OR MEDICATIONS. I CONFIRM THAT CROWN DENTAL STUDIO OR ANY OF ITS AFFILIATES SHALL NOT BE HELD LIABLE FOR ANY UNSUCCESSFUL RESULTS. I HAVE GIVEN A COMPLETE AND TRUTHFUL MEDICAL HISTORY, INCLUDING ALL MEDICINES, DRUG USE AND PREGNANCY.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

I HEREBY CONSENT AND AGREE TO RECEIVE THE FOLLOWING ALTERNATE TREATMENTS IN THE EVENT OF THE DESIRED RESULTS NOT BEING ACHIEVED:

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Crown Dental Studio

PATIENT PARTICULARS:

FULL LEGAL NAME: _____

IDENTITY NUMBER: _____

ADDRESS: _____

_____

_____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

Accepted and Signed at _____ on this _____ day of _____ 20_____

in the presence of the undersigned witnesses

_____

PATIENT NAME:
IDENTITY NUMBER:
CONTACT NUMBER:
EMAIL ADDRESS:

Witnesses:

1. _____
   NAME:
   CONTACT NUMBER:
2. _____
   NAME:
   CONTACT NUMBER: