ENDODONTIC TREATMENT INFORMATION AND INFORMED CONSENT
Dr. Mark A. Kerr – Kerr Endodontics 2007

Patient Name _____ DOB _____ Tooth #_____

I am being provided this information and consent form so I may better understand the treatment recommended for me

ENDODONTIC TREATMENT INFORMATION. Root canal treatment (also called endodontic treatment) requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root (s). **Once treatment is begun, it is absolutely necessary that the root canal treatment is completed.** One or more appointments may be required to complete treatment. It is the patient's responsibility to seek attention if any extraordinary circumstances occur. The patient must follow any and all pre and post-operative instructions given to them. Following root canal treatment, the tooth will need a **final restoration, usually a crown or filling, to restore it to proper function. The tooth may also require additional surgery called crown lengthening. These procedures are a separate cost and performed by a periodontist and/or your general dentist. If you fail to have the tooth restored, you risk failure of the root canal treatment and loss of the tooth.**

ALTERNATIVES TO ROOT CANAL TREATMENT. The alternatives to root canal treatment include: EXTRACTION only. EXTRACTION followed by replacement with an artificial tooth by means of a fixed bridge or removable partial denture. EXTRACTION followed by dental implant and crown placement. NO TREATMENT. If no treatment is chosen, your condition may worsen and you may risk serious personal injury, including severe pain; localized infection; loss of the tooth and possibly other teeth; severe swelling; and/or severe infection that may be potentially fatal.

RISKS. I UNDERSTAND THAT ROOT CANAL THERAPY includes but is not limited to such possible inherent risks as the following:

1. Pain or Discomfort: Swelling, Bleeding; Changes in bite, Injuries to adjacent teeth; Loosening or loss of dental restorations; New infection or worsening of existing infection in the treated tooth or surrounding area. These risks may be evident both during and after completed treatment.

2. Other Risks include: Perforation of the tooth, root, or sinus; Injury to soft tissues adjacent to the tooth; Nerve disturbances resulting in temporary or permanent numbness, itching, burning/tingling of lip, tongue, chin, teeth and/or mouth tissues; Adverse reactions to anesthetic injection, treatment tools and/or solutions used during treatment; Discomfort to jaw from holding mouth open during treatment; Failure of existing restorations or crowns when drilled through for endodontic treatment access that may require replacement..

3. Instrument Separation: Sometimes the small, fragile instruments used in root canal treatment separate inside the canal. This may necessitate either sealing the instrument inside the root, apical surgery or extraction of the tooth.

4. Root Canal Therapy Alone Is Not Always Successful: Many factors contribute to success and not all factors can be determined in advance, if ever. Resistance to infection, specific bacteria causing infection, adequate gum attachment and bone support, oral hygiene, previous dental care, general health, size, shape and location of the canals, blocked, curved, or narrow canals, undetectable root fractures or failure for unexplained reasons are some of these factors. No matter how well treatment has been rendered, there is a possibility of failure and consequent extraction.

ACKNOWLEDGMENT AND CONSENT: I have provided a complete and accurate Medical and Personal History including medication allergies and use. I have been given the opportunity to ask any questions regarding the nature, purpose of root canal treatment and have received answers to my satisfaction. I voluntarily assume any and all 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 and no guarantees have been made to me concerning those results. The fees for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Mark A. Kerr and/or his associates to render any and all recommended treatment advisable to my dental condition, including any and all anesthetics and/or medications and x-rays. I further agree to follow any and all pre and/or post-operative instructions given.

_____ _____
Patient Signature Date

_____ _____
Witness Date