**NON-SURGICAL ENDODONTIC (ROOT CANAL) TREATMENT**

Root Canal therapy is an attempt to save a tooth that otherwise may require extraction. We want our patients to be fully informed about root canal treatment and its alternatives. Thus, we require having their consent before we initiate treatment.

Procedure NSRCT#: ___________________________ Cost ($): _______________ Pt’s Estimated portion due today ($) _______________ Pt Initials: _______

Note: Insurance Estimated Portion: _______________

− The cost of the treatment includes visits to the office and calls for appointments. Ultimately, the patient will be responsible for the potential cost of not following the scheduled treatment.
− Occasionally, a tooth that has received endodontic treatment may require re-treatment, surgery or even extraction, with an additional cost to the patient.
− The radiographs and all written information obtained in this office will remain property of this office. A copy of the final x-ray with a description of the treatment will be sent to your dentist. If you ever require a duplicate of x-rays and chart, this will incur an additional cost to the patient. Initials: _______

CONSENT

I understand that root canal treatment is usually highly successful. Endodontics, as any other medical treatment, is not an exact science. I understand that a successful outcome of the treatment cannot be guaranteed. Initials: _______

There are certain potential risks inherent in any treatment plan or procedure. I understand that the risks include, but are not limited to: complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections. The complications include, but are not limited to: swelling, sensitivity, bleeding, pain, infection, cold sores, numbness and tingling sensation (which is transient but on infrequent occasions may be permanent) to the lip, tongue, chin, gums, cheeks, and teeth; reactions to injections, changes in occlusion (bites); jaw muscle spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, crowns or bridges; referred pain to ear, neck and head; nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure. Fractures of the tooth (teeth) or crown(s) may occur during or after treatment. Initials: _______

I do understand that during and following treatment, I may have periods of discomfort. I further understand that many factors contribute to the success or failure of root canal therapy, which cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of these factors include, but are not limited to, my resistance to infection, the shape and location of the canal anatomy, my failure to keep scheduled appointment(s), the failure of my having the tooth restored following the treatment, periodontal (gum) involvement, or an undetected or an after-the-fact caused split (crack) in the tooth. Initials: _______

I further understand that specific to non-surgical root canal therapy, risks include, but are not limited to, the possibility of instruments breaking within the root canals; perforations (extra opening) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require dental surgery. These complications may include but are not limited to, blocked canals due to filling or prior treatment, natural calcification, broken instruments, curved roots, periodontal (gum) disease, and splits or fractures of the teeth. Initials: _______

I understand that during the following treatment, I am to contact Dr. Dominguez’s office if I experience any unexpected reactions. It will be my responsibility to contact my referring dentist to see if any other treatment requires attention, including a crown over the endodontically treated tooth. At the end of the endodontic procedure, a recall appointment should be made by the patient within one year to evaluate healing. Initials: _______

I further understand that prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, which may be exaggerated by the use of alcohol, tranquilizers, sedatives or other drugs. It is not advisable to operate any vehicle or hazardous device until recovered from their effects. The use of antibiotic (penicillin, etc) drugs may have an adverse reaction on the effect of birth-control pills. Initials: _______

I hereby give permission for the use of my x-rays and/or photographs taken during the course of the treatment to be used in lectures, seminars and/or printed in professional journals purely for educational purposes. Initials: _______

I have been given the opportunity to have my questions answered in terms I understand concerning the nature of the treatment, the inherent risks and the alternatives to this treatment. I understand that I always have the option of no treatment or extraction, as opposed to acceptance and/or continuance of recommended treatment. Initials: _______

Patient Name: ___________________________________ Patient signature: ____________________________ Date (mm/dd/yy): / / /

(Print Name) (If a minor, signature of a parent or legal guardian)