Dentist 4 | Better bites, better smiles, better life.
better quality of life

D4-CONSENT-RCT

PROCEDURE INFORMATION

PATIENT NAME: _____ _____ _____ _____

LAST FIRST MI DATE OF BIRTH

PROCEDURE: **ROOT CANAL TREATMENT** _____

PROCEDURE TEETH (S)

DOCTOR NAME: _____

COMPLETE NAME

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

DETAILS OF CONSENT

Condition

My doctor has explained the nature of my condition to me: Deep Tooth Decay (Cavities are permanently damaged areas in the hard surface of your teeth that develop into tiny openings or holes. Cavities, also called tooth decay or caries, are caused by a combination of factors, including bacteria in your mouth, frequent snacking, sipping sugary drinks and not cleaning your teeth well.

If cavities aren't treated, they get larger and affect deeper layers of your teeth. They can lead to a severe toothache, infection and tooth loss. Regular dental visits and good brushing and flossing habits are your best protection against cavities and tooth decay).

Procedure – Root Canal Treatment

My doctor has proposed the following procedure to treat or diagnose my condition: Root canal treatment, also called endodontic treatment, involves relieving pain and discomfort by removing the nerve tissue (called pulp) located in the center of the tooth and it's root or roots (called the root canal). Treatment involves drilling through the biting surface of the tooth and exposing the pulp, which is removed with very fine metal files. Medications may be used to sterilize the interior of the tooth to prevent further infection.

Each empty root canal is filled with a rubber-like material and medicated cement. Occasionally a metal pin (called a post) is also inserted into the canal to help restore the tooth. The opening in the tooth is closed with a temporary filling. At a later appointment, a cap (also called a crown) may be placed. Twisted, curved or blocked root canals may prevent removal of all inflamed or infected pulp. Since leaving any pulp in the root canal may cause your symptoms to continue or worsen, this might require an additional procedure called an apicoectomy. Through a small opening cut in the gums and surrounding bone, any remaining pulp is removed and the root canal is sealed. An apicoectomy may also be required if your symptoms continue and your tooth will not heal.

Once the root canal treatment is completed, it is essential to return promptly to have treatment completed. Because a temporary seal is designed to last only a short time, failing to return as directed to have the tooth sealed permanently with a crown could lead to the deterioration of the seal, resulting in decay, infection, gum disease, and the possible premature loss of the tooth.

While we believe that patients have a right to be informed about any treatment, the law requires extensive disclosure of the risks of dental procedures and anesthesia, many of which are extremely unlikely to occur, but can be alarming for the patient. Please feel free to the doctor about the frequency of any risks or complications disclosed herein that might apply to you based on our clinical experience and that of other dental professionals.

1. After a careful oral examination and study of my dental condition, the doctor has advised me that my Deep Dental Caries may be restored with a Crown. I hereby authorize and direct the doctor and his assistants to treat my condition.

2. The procedure I choose to treat this condition is understood by me to be The deep decayed tooth structure is removed, involves relieving pain and discomfort by removing the nerve tissue (called pulp) located in the center of the tooth and it's root or roots (called the root canal) and the cavity is filled with a biocompatible material, and posterior fabrication of a crown on top of the tooth.
3. Additional treatment procedures may include a, metal or fiberglass pin (called a post) is also inserted into the canal to help restore the tooth, core buildup with resin composite material, adjustments on the opposite or adjacent teeth, apicoectomy, redo the root canal treatment, reste with a crown or inlay/onlay type restorations, and others treatments. I understand that the purpose of this procedure is to allow me to have healthy teeth without any bacteria in my teeth.
4. I have also been advised that other alternative treatments done for patients in my condition include, but are not limited to, crown, inlay/onlay ceramic restoration, teeth extraction and dental implant, teeth extraction and bridge, or other options. I understand and choose to undergo the root canal treatment and the fabrication of a single crown, bridge or inlay/onlay restoration.
5. I also understand that during the course of the procedure, unforeseen conditions may arise that necessitate an extension or alteration of the planned procedure contained herein. I therefore authorize and request that the doctor and his assistants under his direction perform such procedure as found necessary and administer such drugs and treatments as required in their professional judgment.
6. I have had the opportunity to discuss with the doctor the planned procedure and my postoperative responsibilities. I should take any antibiotics, pain medication if i needed. If I experience an unusual amount of pain I should contact the doctor or his office immediately, as it may signify a problem.
7. I understand no guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I also understand that due to individual patient differences and the imperfections of the art and science of endodontics and restorative dentistry, there exists a risk of failure or necessity of additional treatment despite appropriate care. I have been advised that the root canal treatment has shown long term success rates. However, I understand that such disclosure is not to imply that I personally can expect such a favorable long-term result and that there will be no refund of fees from the dentist. However, should I elect to have another doctor to do a new root canal treatment, I am solely responsible for all costs and fees incurred in doing so and hereby release the doctor from any such costs and fees imposed by the other doctor.

Alternatives

My doctor has explained the following medically acceptable alternatives to be: crown, inlay/onlay ceramic restoration, teeth extraction and dental implant, teeth extraction and bridge, or other options. Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

This course of treatment will help to relieve your symptoms. If you do not have root canal treatment, your discomfort could continue and you could face the risk of a serious, potentially life threatening infection abscesses in the tissue and bone surrounding your teeth and eventually, the loss of the tooth. Additional Info: Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are:

I. **Bleeding, pain, soreness, and infection:** During and after treatment, you may experience bleeding, pain, swelling or discomfort for several days, which may be treated with pain medication. You may also experience an infection which would be treated with antibiotics.
2. **Reaction to anesthesia and / or sedation:** To keep you comfortable during treatment you will receive a local anesthetic and possibly a sedative (tranquilizer). In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing, which

increases the chance of swallowing foreign objects during treatment. Sedatives may temporarily make you drowsy or reduce your coordination.
3. **Stiff or sore jaw joint:** Holding your mouth open during treatment may temporarily leave your jaw feeling stiff and sore and may make it difficult for you to open your mouth wide for several days afterwards. Treatment also may leave the corners of your mouth red or cracked for several days.
4. **Broken instruments:** Occasionally a root canal instrument will break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its' location, the fragment can be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical stainless steel, so this causes no harm). It may also be necessary to perform an apicoectomy to seal the root canal.
5. **Overfill:** As a result of filling the root canal, the incomplete formation of your tooth or an abscess at the end of the tooth (called an apex), an opening may exist between the root canal and the bone or tissue surrounding the tooth. This opening can allow filling materials to be forced out of the root canal into the surrounding bone and tissue. An apicoectomy may be necessary for retrieving the filling material and sealing the root canal.
6. **Need for further treatment:** Teeth that receive root canal treatment may be more prone to cracking and breaking over several years' time, which may ultimately require a bridge or partial denture. In some cases, root canal treatment may not relieve all symptoms. If you suffer from gum disease (also called periodontal disease), this can increase the chance of losing a tooth even though root canal treatment was successful.

There will be no refund of fees from the dentist in the event of complications requiring additional procedures to salvage the teeth.

Drugs, Medications, and Anesthesia

Antibiotics, Pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection.

No guarantee

The practice of dentistry is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

MY RESPONSIBILITY

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health. It is my responsibility to see the doctor at least once a year for evaluation and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after procedure to ensure success in the restoration.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

MISCELLANEOUS

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this procedure, and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

SIGNATURE

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr._____to perform the procedure listed in the title above.I know that I am free to withdraw from treatment at any time.

Patient or Representative Signature **Date**

If not the patient, what is your relationship to the patient?

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

Dentist Signature **Date**

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