

I UNDERSTAND that dental treatment requiring ROOT CANAL THERAPY, ENDODONTIC PROCEDURES, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) I understand injury to the nerves of the lips, tongue, tissues in the floor of the mouth, and/or the cheeks, etc. can possibly happen. These potential nerve injuries can cause numbness, tingling, burning, and loss of taste in the case of the tongue may be of a temporary nature lasting a few days, weeks, or months, and could possibly be permanent.

_____(initials) The treated tooth may remain tender or even painful for a period of time, both during and after completion of therapy. If pain is severe or swelling occurs, it is imperative to call the doctor immediately.

_____(initials) In some teeth, conventional root canal therapy may not be sufficient. If the canals are calcified, roots excessively curved or inaccessible, inadvertent pulp chamber or root perforation may occur, requiring referral to a specialist. If there is infection in the bone surrounding the tooth, healing may be prolonged and/or referral to a specialist for retreatment, extraction or a surgical apicoectomy may become necessary. In unusual cases, hospitalization or I.V. antibiotics may be necessary to treat an endodontic infection.

_____(initials) Teeth receiving root canal therapy must be protected. After treatment, your tooth, in some instances, will have a temporary filling. Should this come out during or after treatment, you must contact the doctor immediately to arrange for replacement. Root canal treated teeth become brittle and, due to undermined or reduced tooth structure, may be subject to cracking or fracture. Crown placement on the treated tooth is the best precautionary measure to help avoid this from occurring; this procedure should be performed as soon as possible after treatment.

_____(initials) Root canal therapy is not always successful. Many factors influence success: adequate gum tissue attachment and bone support, proper oral hygiene, previous and present dental care, general health, trauma, pre-existing undetected root fractures, accessory or lateral canals, etc. It may be difficult to place filling material to the end of the root (underfill) or some filling material may extrude from the tooth (overfill), which can, in some cases cause inflammation, nerve damage resulting in temporary, or in rare cases, permanent numbness of the lip. Surgery may be required to remove excess filling material or residual infection. There is always the possibility of treatment failure, making additional root surgery (apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic therapy, the chance for perforation is enhanced due to obscured anatomy.

_____(initials) A bridge abutment, or crown, may be damaged or destroyed during rubber dam application, access preparation, or other procedures as part of root canal therapy. Porcelain is particularly susceptible to fracture or cracking, and an existing porcelain crown may have to be remade, particularly if the pre-existing crown is all-porcelain in design.

_____(initials) Root fracture is one of the primary reasons for root canal failure. Unfortunately, "hairline" cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, initial cracking of the anatomical crown portion of the tooth, pre-existing large fillings, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.

_____(initials) There are alternatives to root canal treatment. These alternatives may include: no treatment, extraction, extraction followed by bridge or partial denture placement, and/or extraction followed by implant and crown placement.

_____(initials) Because of the fragility and small diameter of root canal instruments used in root canal treatment, there always exists the possibility of instrument separation (breakage) which may or may not be detected at time of treatment. Although it is often possible to bypass or incorporate separated instruments within the filling material, instrument separation may result in the need for retreatment, surgical retrieval or extraction of the tooth.

_____(initials) Unusual reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to the doctor's instructions. If you are a female on oral contraceptives, you must be aware that antibiotics can render those contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during treatment.

_____(initials) During root canal therapy, irrigating solutions are used to enhance tissue removal and to disinfect the tooth. Occasionally these irrigating solutions may enter the surrounding tissue or bone causing pain, swelling, inflammation and in rare cases, tissue necrosis.

_____(initials) There is the potential for long appointments to complete the procedures, and jaw muscles may be sore following the procedure. A pre-existing jaw problem, or temporomandibular dysfunction, may be aggravated by endodontic retreatment due to extended opening.

_____(initials) It is absolutely necessary that root canal therapy be completed once started. One or more appointments may be required.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warranties have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name Signature of Patient, Legal Guardian, or Authorized Representative Date

Tooth Number(s) Witness to Signature Date

Healthcare Provider's Name Signature of Healthcare Provider Date



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