PREMIER ENDODONTICS

Informed Consent to Endodontic Therapy

Patient Name: _____ DOB: _____

This is my consent to authorize Dr. Batsevitsky / Jones / Kiebish to perform endodontic therapy on tooth/teeth# _____. I further give my consent to the above named dentist to take any x-rays, administer any medications, anesthetics, drugs, and services or procedures that she deems necessary or advisable as a corollary to the planned endodontic treatment.

I understand that endodontic therapy is a procedure to retain a tooth that may otherwise require extraction.

Endodontic therapy results in the removal of the pulp tissue (nerve and blood vessels) from the inside of the tooth then seals the space with a filling material. Endodontic therapy enjoys a high degree of success, but because it is a biological procedure, success cannot be guaranteed or warranted. Occasionally, a tooth which has had endodontic treatment may require retreatment, periradicular surgery, or even extraction.

During treatment there is the possibility of instrument separation within the tooth, perforation of tooth structure in gaining access to the canals, and fracturing of the tooth itself. Permanent damage and/or loss of crown/bridges may occur during treatment.

Following treatment the tooth must be restored to function with a protective restoration, usually a post and crown.

Some teeth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices include, but are not limited to, pain, swelling, loss of tooth, infection and spread of infection to other areas.

Complication of endodontic therapy and anesthesia may include swelling, pain, restricted jaw opening, infection, bleeding, sinus involvement, and numbness of the lip, gum and/or tongue, all of which are rarely permanent.

The nature of endodontic therapy has been explained to me. I have had the opportunity to have my questions regarding treatment answered by the doctor to my satisfaction.

_____ _____

Patient Signature Date