Gregory S. Brya, DDS, PLLC / Patrick S. Sweeney, DDS

drbrya.com drbrya@drbrya.com

4780 Okemos Road | Suite #1 • Okemos, MI 48864 (517)381-8181

INFORMED CONSENT FOR ROOT CANAL THERAPY

Patient Name: _____ * _____ * ___ _____

Last First MI Preferred Name

Date: * _____

Facts for Consideration:

Root canal therapy, also called endodontic treatment, involves removing the nerve tissue (called pulp) located in the center of the tooth and its root or roots (called the root canal). Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp, which then are removed. Medications may be used to sterilize the interior of the tooth to prevent further infection. Tooth canal treatment may relieve symptoms such as pain and discomfort. If any unexpected difficulties occur during treatment, you may be referred to an endodontist, who is a specialist in root canal therapy.

*Each empty root canal that can be located is filled. Occasionally, 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 crown will be placed. It is a separate dental procedure not included in this discussion.

*Twisted, curved, accessory, or blocked 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 infected tissue is removed and the root canal is sealed. An apicoectomy may also be required if your symptoms continue and the tooth does not heal.

*Once the root canal therapy is completed, IT IS ESSENTIAL TO RETURN PROMPTLY TO BEGIN THE NEXT STEP IN TREATMENT.

*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 or filling can lead to other problems such as deterioration of the seal, resulting in decay, infection, gum disease, fracture, and the possible premature loss of the tooth.

Benefits of Root Canal Therapy, Not Limited to the Following:

Root Canal Treatment is intended to allow you to keep your tooth for a longer time, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment has been recommended to relieve the symptoms reported by the patient.

Risks of Root Canal Therapy, Not Limited to the Following:

I understand that following treatment I may experience BLEEDING, PAIN, SWELLING, AND DISCOMFORT FOR SEVERAL DAYS, which may be treated with pain medication. it is possible infection may accompany root canal therapy and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen or if I experience fever, chills, sweats, or numbness.

I understand that I will receive a local anesthetic and/or other medications. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. in case of swallowing or aspiration of a foreign object, a chest x-ray and examination by my medical doctor may be necessary to determine the location of the object and proper treatment. Depending on the anesthesia and medication administered, I MAY NEED A DESIGNATED DRIVER TO TAKE ME HOME. Rarely, temporary or permanent nerve injury can result from an injection.

I understand that all medications have the potential for accompanying risks, side effects, and drug interactions and that it's critical that I tell my dentist of all medications I am currently taking.

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it more difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. I will notify the office if this or other concerns arise.

I understand that occasionally a root canal instrument may break off in a root canal that is twisted, curved, or blocked with calcium deposits. Depending on its location, the fragment may 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 usually causes no harm). It may also be necessary an apicoectomy, as desribed above, to seal the root canal.

I understand that during treatment the root canal filing material may extrude out the root canal into the surrounding bone and tissue. Occasionally, an apicoectomy may be necessary for retrieving the filling material and sealing the root canal.

I understand that teeth that receive root canal therapy may be more prone to cracking and breaking over time, which may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal therapy may not relieve all symptoms and the tooth may need to be retreated or extracted. The presence of gum disease (periodontal disease) can influence the chance of losing a tooth even though root canal therapy was successful.

Consequences if No Root Canal Therapy Is Administered, Not Limited to the Following:

I understand that if I do not have root canal therapy, my discomfort may continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually, the loss of my teeth and/or adjacent teeth.

Alternative Treatments if Root Canal Therapy is Not the Only Solution, Not Limited to the Following:

I understand that depending on my diagnosis, alternatives to root canal therapy may exist which involved other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal therapy. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an implant. I asked my dentist about alternatives and associated costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits and costs.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I give my consent for the treatment as described above.

☐ * **By checking this box, I acknowledge that I have read this statement and agree to the contents.**

Signature of patient, parent or guardian (responsible party):

Signature _____ **Date** _____

I attest that I have discussed the risks, benefits, consequences and alternatives to teeth whitening with the patient/parents who had the opportunity to ask questions & I believe my patient/parents understands what has been explained.

Signature of Dentist/Provider:

Signature _____ **Date** _____

Response Date: _____