Signature Endodontics
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INFORMED CONSENT

I _____ have been advised by my referring dentist that I may require root canal treatment on tooth #_____ after my consultation with Dr. Samuel Ip.

I understand that root canal treatment is an attempt to save my tooth due to loss of vitality from infection, decay, fracture, or to obtain sufficient retention for restorations. The alternative to root canal therapy is extraction.

I understand the following risks and complications may arise as a result of root canal therapy. I have had the opportunity to discuss any questions I may have regarding this procedure.

1. Root canal therapy requires anesthesia and multiple radiographs (X-rays). Local anesthesia may cause trismus (difficulty in jaw opening) or parasthesia (temporary or permanent loss of sensation).
2. Allergic reactions to medications or anesthetics.
3. Separation of root canal instruments during treatment which may, in the judgment of the doctor be left in the root canal or require surgical procedure for removal.
4. Perforation of the root canal due to curved or calcified roots and/or existing conditions. This may require additional surgical treatment or extraction.
5. Premature tooth loss may result from fractures that can occur during root canal treatment or from progressive periodontal (gum) disease.
6. Access through a crown or bridge (existing restorations) may result in damage to restorations.
7. Post operative discomfort or swelling may occur. Post surgical complications include: discomfort, pain, bruising, swelling, bleeding, trismus, nerve trauma (which may result in numbness or altered sensation).
8. The tooth may darken or become susceptible to fracture due to loss of vitality. We recommend placement of a final restoration by your referring dentist as soon as possible.
9. Root canal therapy through crowns may hide existing decay or cracks that may not be visible.

I understand that at any time during treatment, common medications may be prescribed that have side effects such as nausea and diarrhea. In any adverse side effects such as itching, rash or hives occur, I am to stop the medication and call the doctor who prescribed them.

My signature certifies that I have read, discussed, and understand all terms pertaining to root canal therapy and consent to recommended treatment.

Patient Signature_____ Date_____

Print Name_____