# Consent for Endodontic Surgery

We would like our patients to be informed about various procedures involved in endodontic treatment and have their consent before starting treatment. Endodontic (root canal) treatment, or when needed, endodontic surgery is performed in order to save a tooth which otherwise might need to be removed. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

GENERAL RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation medications, analgesics (pain killers), anesthetics, and injections. These complications may include: swelling; sensitivity; bleeding; pain; infection; reactions to injections; changes to occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; vomiting; allergic reactions; delayed healing; sinus perforations; treatment failure and/or numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient (temporary) but on infrequent occasions may be permanent.

________**Risks more specific to surgical endodontic (root canal) treatment: (Please initial after reading)**

1. All teeth have the possibility of having cracks or splits in the crown and/or root structure. If present, the extent of a cracked or split tooth may not be able to be determined prior to surgical endodontic treatment and may result in the need for extraction of the tooth.
2. During treatment, complications may be discovered which make treatment impossible. These complications may include limited surgical access into the region that requires treatment, curved roots, periodontal (gum) disease, splits or fractures of teeth.
3. During surgical root canal treatment adjacent teeth are at risk to receive some pressure due to the nature of the procedures. In few cases this may result in loss of adjacent tooth structure, damage to the roots of adjacent teeth and/or broken fillings, restorations and crowns of adjacent teeth.
4. Most endodontic surgeries involve slight recession (shrinkage) of the gingival tissues (gums). This may result in exposure of crown margins or root structure and may slightly change the aesthetics of the involved region.
5. Surgical root canal treatments are biological procedures which mean perfect results are not guaranteed or warranted. Surgical root canal treatments have a success rate of 80-90%.
6. Medications may be prescribed. Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs.) It is not advisable to operate any vehicle or hazardous device until recovered from their effects.
7. Paresthesia is a potential risk with all endodontic and facial surgeries. Paresthesia means numbness that can occur in the lip, tongue, chin, gums, cheeks, and teeth, which is transient (temporary) but on infrequent occasions may be permanent.
8. Upper posterior teeth are located in close proximity to the sinus cavity. During endodontic surgery of these teeth there may be a communication between the sinus cavity and the roots of the tooth or the infected tissues around the tooth. In these circumstances in order to completely treat the involved tooth a sinus perforation may occur. In the event of a sinus perforation your treating doctor will provide the treatment needed to encourage natural healing of the sinus perforation. This may result in some additional post-op responsibilities for the patientto follow and in few cases may require additional follow-up treatment and care.

**PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM.**

**THE PATIENTS RESPONSIBILITIES: (Please initial after reading):**

1. __________ I have read or have been informed from the surgical packet provided by Center for Endodontic Care on all pre-surgical and post-surgical responsibilities I should do to best take care of my mouth for this surgical procedure. I am also aware that I am responsible to schedule a 1 week post-op appointment to have the remaining sutures removed and be evaluated for healing.
2. __________ I understand that the payment for my treatment is due in full at the time of service, OR if I have dental insurance, I will remit 50% of my fee. I understand I am responsible to pay for any remaining balance my insurance does not cover.

I,____________________________________, hereby authorize the above named doctors of the Center for Endodontic Care and any other agents or employees of the Center for Endodontic Care to treat the condition(s) described below. The procedure(s) necessary to treat the condition(s) has been explained to me, and I understand the nature of the procedure to be:

A. Surgical root canal therapy (apicoectomy) on tooth number(s) ________________________________
B. Other __________________________________________________________________________________

**ALTERNATIVE TREATMENT OPTIONS: (Please initial after reading.)**

_______ I have been informed of possible alternative methods of treatment including no treatment at all; waiting for more definite development of symptoms; and tooth extraction. Risks involved with these choices might include pain, infection, swelling, loss of teeth, and infection of other areas.

**DO YOU HAVE ANY FURTHER QUESTIONS? (Please initial after reading.)**

_______ My treating doctor and the staff of the Center for Endodontic Care have provided me with answers to all of my questions concerning the nature of treatment; the inherent risks; and the alternatives to this treatment.

**THE FEE FOR THE TREATMENT IS:**

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|---|---|
| Surgical Root Canal Treatment | $ ___________________________________ |
| Nitrous Oxide ($90.00) | $ ___________________________________ |
| Other: ___________________________________ | $ ___________________________________ |
| **TOTAL** | $ ___________________________________ |

All of the foregoing has been explained to me. I understand the information that has been provided to me and my signature below indicates that I consent to the treatment.

**Patient Signature** _____________________________________ **Date** ________________________________

**Parent/Guardian Signature** _____________________________ **Date** ________________________________

**Staff Signature** _______________________________________ **Date** ________________________________

**Copy provided to patient:** **Date** ________________________________