

**Mack Endodontics D.D.S., P.C.
704 W. Brookhaven Circle
Memphis, TN 38117
901-683-2221**

Consent for Endodontics Treatment

Patient's Name _____ **Tooth/Teeth #** _____

Please be reassured that we use accepted infection control procedures and universal precautions for the protection of our patients and staff.

While serious complications associated with root canal therapy are very rare, we would like our patients to be informed about the various procedures involved and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to attempt to save a tooth which otherwise might need to be removed. Endodontic (root canal) therapy is cleaning, shaping, and disinfecting and filling the space inside the root of the tooth. A treated tooth usually functions normally and is a pulp less tooth, not a dead tooth. Treatment will usually require one visit but may require more visits depending on the condition and complexity of your tooth. Local anesthetic will be used to anesthetize (numb) your tooth and digital x-rays, which require 50-70% less radiation than conventional x-rays, will be taken as indicated. (X-rays are included as part of your evaluation and/or treatment) Please advise the doctor or staff if you are pregnant or could be pregnant at the time of treatment.

Risks: Included (but not limited to) are complications resulting from the use of dental instruments (separated instruments), drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications may include swelling, sensitivity, bleeding, pain, infection, reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, referred pain, loosening of teeth, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, treatment failure and numbness or tingling sensation in the lip, tongue, chin, gums, cheek and teeth. During treatment, complications may be discovered which make treatment impossible or which may require dental surgery. Teeth may fracture after treatment has been completed or in-between appointments resulting in possible tooth loss. If damage occurs to a crown during treatment, the patient is responsible for having it replaced at their expense.

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination. It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Birth control pills may not be effective when taking antibiotics.

I, the undersigned, being the patient (parent or guardian of the above minor patient), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that, UPON COMPLETION OF MY ROOT CANAL TREATMENT, I AM TO RETURN TO MY GENERAL DENTIST FOR A PERMANENT RESTORATION (CORE BUILD-UP AND CROWN) IMMEDIATELY! Although root canal therapy has a high degree of success, it can not be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery or extraction. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

Patient's Signature _____ Date _____
Parent or Guardian's Signature (if patient is a minor) _____