INFORMATIONAL USE ONLY

Patient Name: _____

Informed Consent for Endodontic Treatment

1) On (date) _____, Dr. _____ discussed with me the following informed consent form for endodontic treatment of the condition(s) described below.

_____

2) The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be:

_____

3) The prognosis for this(these) procedure(s) was described as:

_____

4) I have been informed of possible alternative methods of treatment including:
   a) No treatment at all.
   b) Extraction
   c) _____

5) The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive.
   a) swelling; sensitivity; bleeding; pain; infection;
   b) numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent;
   c) reactions to injections;
   d) changes in occlusions (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty;
   e) loosening of teeth, crowns or bridges; or damage to existing restorations which may necessitate replacement of the restoration;
   f) referred pain to ear, neck and head; delayed healing; sinus performance;
   g) treatment failure; complications resulting from the use of dental instruments (broken instrument-perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face;
   h) reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effects of birth control pills.
   i) further treatment may be necessary.

6) It has been explained to me and I understand that the results of treatment is not guaranteed or warranted and cannot be guaranteed or warranted.

7) I have been given the opportunity to discuss this form and question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

8) This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

Patient's Signature _____ Date/Time _____

Doctor's Signature _____ Date/Time _____

Witness's Signature _____ Date/Time _____