CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You are required to sign it prior to the initiation of treatment; however, it does not commit treatment

You have been referred to our office because of an apparent or suspected endodontics problem. Endodontics (root canals) are generally done on teeth where the vital tissue has become diseased. The procedure entails cleaning and sealing the canals found within the tooth so that you **can preserve your natural teeth.** Root canals are done in order to save teeth that would otherwise need to be extracted. Root canal therapy (RCT) has a very high degree of success, but results cannot be guaranteed. Studies have been shown that diabetic patients with apical lesions have an impaired healing potential vs healthy patients regardless of how well the RCT is done. We will do our best to advise you of the anticipated outcome.

Occasionally a tooth, which has had root canal treatment, may require re-treatment, surgery or even extraction. During endodontic treatment there is the possibility of instrument separation within the root canal; perforations (extra openings); damage to bridges, existing fillings, crowns or veneers; missed canals, loss of tooth structure in gaining access to the canals and fractured teeth.

Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to pain, infection, swelling, and loss of teeth and infection to other areas.

Many teeth, especially back teeth, require a cuspal coverage restoration (crown or onlay) after the root canal treatment has been completed. The non-restored tooth is susceptible to fracture, so you will need to see your dentist for a full restoration as soon as possible. Our fee only includes a temporary filling, unless otherwise stated.

Occasionally medication will be prescribed by your endodontist. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. Certain medication may cause allergic reactions, such as hives, or intestinal discomfort. If any of these symptoms occur, call immediately. It is the patient's responsibility to report any changes in their medical history.

I fully understand the above statements in this consent form. I give Dr. Mann and Dr. Ortiz permission to record, videotape and/or take photos of my procedure for my medical record and/or for educational or insurance purposes.

If you have any questions about the proposed procedure, please ask.

_____ _____

Patient Signature Date

If patient is under 18, a parent or guardian must sign the consent form.