



Discussion and Informed Consent for Root Canal Treatment

Facts for Considerations/Patient initials required

_____ Root canal treatment, also called endodontic treatment involves removing the nerve tissue (called pulp) located in the center of the tooth and its root or roots (called the root canal). Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp, which then are removed. Medications may be used to sterilize the interior of the tooth to prevent further infections. Root canal treatment may relieve symptoms such as pain and discomfort. If any unexpected difficulties occur during treatment, Dr. Mark Poitras may refer you to an endodontist, who is a specialist in root canal treatment.

_____ Twisted, curved, accessory, or blocked canal(s) may prevent removal of all of the inflamed or infected pulp. The presence of any residual pulp in the canal(s) may cause your symptoms to continue to worsen. This might require an additional procedure called an apicoectomy. A small opening is cut in the gums and surrounding bone; any infected tissue is removed and the canal(s) are sealed. An may also be required if your symptoms continue and the tooth does not heal.

_____ Each empty canal(s) that can be located is filled with a material designed specifically for root canal therapy. Sometimes a canal is present but cannot be located. Occasionally, a post is also inserted into the canal to help restore the tooth. After filling the opening in the tooth, the tooth is closed with a temporary filling. At a later appointment, a permanent filling or crown may be placed. This is a separate dental procedure not included in this discussion.

_____ Once the root canal treatment is completed, it is essential to return promptly to begin the next step of treatment. Because a temporary seal is designed to only last only a short time, failing to return as directed to have the tooth sealed permanently with a crown or filing can lead to other problems such as the need to repeat the treatment at an additional cost, or the deterioration of the seal, resulting in decay, infection, gum disease, fracture, and the possible loss of tooth.

_____ Even in cases with no complications, where a crown or filling is placed right away, this procedure will not prevent further tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had a root canal treatment and may require endodontic re-treatment, endodontic surgery, or tooth extraction.

Use of Local Anesthesia

_____ Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection.

_____ Risks include but are not limited to: It is normal for the numbness to take time to wear off after treatment, usually four to six hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur.

_____ Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during the dental treatment.

_____ For ALL female patients: Because anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the provider if she could be or is pregnant. Anesthetics, medications and drugs may affect the behavior of a nursing baby. In either of these situations, the anesthesia and treatment may be postponed.

Benefits of Root Canal Treatment, Not Limited to the Following:

_____ Root canal treatment is intended to extend the life span of your tooth, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment may also be recommended to relieve the symptoms that may be associated with the diagnosis described above.

Risks of Root Canal Treatment, Not Limited to the Following:

_____ I understand that following treatment I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated by over-the-counter pain medication or anti-inflammatories. It is possible infection may accompany a root canal treatment and may require treatment with systemic antibiotics. I will immediately contact the office if conditions worsen or if I experience fever, chills, sweats, numbness, sinus problems, severe pain or swelling.

_____ I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking and any medical conditions I may have. I attest that my medical history is up to date and accurate so that my dentist may ensure my safety during the procedure.

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify the office if I experience persistent trismus or other similar concerns arise.

_____ I understand that occasionally a root canal instrument, may separate in a root canal that is twisted, curved, or blocked with calcium deposits. Depending on its location, the fragment may be retrieved or it may be necessary to seal it in the root canal (these instruments are sterile, non-toxic surgical grade stainless steel, and typically causes no harm). It may also be necessary to perform an apicoectomy as described above, to seal the end or lower part of the root canal.

_____ I understand that during treatment the root canal filling material may extrude out the root canal into the surrounding bone and tissue. Occasionally, apicoectomy may be necessary for retrieving the filling material and seal the canal.

_____ I understand that other complications which may occur include, but not limited to: perforations (extra openings) of the canal made by an instrument, blocked root canals that cannot be completely cleaned and filled, fracture, chipping, or loosening of existing adjacent tooth or crown, requiring replacement at an additional cost, temporary or permanent numbness or painful nerve sensations.

_____ I understand that teeth that have received root canal treatments may become brittle and be more prone to cracking and breaking over time, which may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal treatment may not relieve all symptoms. The presence of gum disease (periodontal disease) can increase the chance of losing a tooth even though root canal treatment was successful.

_____ I understand that root canal treatment may not relieve symptoms, and I may need my tooth extracted.

Consequences if No Root Canal Treatment is Administered, Not Limited to the Following:

_____ I understand that if I do not have root canal treatment, my discomfort may continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually, the loss of my tooth and/or adjacent teeth.

Alternative Treatments if Root Canal Treatment; Not Limited to the Following:

_____ I understand that depending on my diagnosis, alternatives to root canal treatment may exist which involve other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an implant. I have asked my dentist about the alternatives and possible associated expenses. My questions have been answered to my satisfaction regarding the procedures, its risks, benefits, alternatives and cost.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the conditions listed above.

Initial only one of the spaces below that applies to you:

_____ I have had my questions answered to my satisfaction. I consent to have Dr. Mark Poitras perform the treatment as discussed. I authorize and direct this dentist, with his associates, to do whatever they deem necessary and advisable under the circumstances.

Or

_____ I refuse to give my consent for the proposed treatments(s) as described above and understand the potential for consequences associated with this refusal.

Patients Signature (or Patient's Representative) Date

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