DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

CONSENT FOR SURGICAL ROOT CANAL TREAMENT
Page 1 of 2

_____
Patients Name Date

Please initial each paragraph after reading. If you have any questions, please ask the doctor BEFORE initialing.

You have the right to be informed about you diagnosis and planned surgery so that you can decide whether to have a procedure or not.

Your diagnosis is: _____

Your planned surgery is: _____

Alternative treatment methods include: _____

All surgeries have risks. The most common risks for the procedure include the following:

_____ 1. Bleeding, swelling, soreness, bruising, infection, stretching of the corner of the mouth, stiffness of the jaw joints (TMJ), unexpected drug reactions or allergies, fracture of the jaw or parts of bones supporting teeth, and difficulty eating for several days.

_____ 2. Although usually only one incision (cut) is needed to get to the root end to be treated, sometimes other incisions are needed.

_____ 3. Numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the roots being close to the nerves which can be injured or damaged. Usually the numbness or pain goes away, but in some cases, it may be permanent.

_____ 4. When operating on upper back teeth, there is a chance of entering the sinus. This may need more care, including medications, and may possible result in an opening between mouth and sinus that may require further care. Rarely, the same complication may involve the nasal cavity.

_____ 5. Certain filling materials used to “Plug” the end of the tooth’s root canal may cause some discoloration of the gum tissue over the area.

_____ 6. Once in a while the tooth root may be cracked which makes the success of the planned treatment more difficult. If that is the case, we may have to pull the tooth.

_____ 7. Surgical root canal treatment is not exact so success is not guaranteed. We might need to treat the tooth again, and there are some things like very tiny hidden cracks in the roots that might cause problems later and the tooth might have to be pulled.

_____ 8. There may be injury or damage to tooth roots that are close by. You may laterneed root canal treatment, or even lose certain teeth.

_____ 9. If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done.

_____ 10. **ANESTHESIA**

□ Local Anesthesia
□ Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
□ Oral Premedication with Local Anesthesia
□ Intravenous Sedation with Local Anesthesia
□ General Anesthesia with Local Anesthesia

_____ 11. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, and allergic reactions. There might be swelling where an injection was given (phlebitis) that might cause discomfort and/or disability for a long time, and might need special care. You might have nausea and vomiting form the IV anesthesia, but this doesn't happen often. IV sedation and general anesthesia are serious medical procedures. There are safe, but there are rare risks of heart problems, heart attack, stroke, brain damage or death.

_____12. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**:

A. Because you will be very sleepy for some time after having an IV anesthetic medication, a responsible adult MUST come with you to drive you home and stay with you until you are recovered enough to take care of yourself. This recover time may take up to 24 hours.

B. During this time you should not drive, operate complicated machinery or devices, or make important decisions such as signing document, etc.

C. You MUST have a completely empty stomach. IT IS VERY IMPORTANT THAT YOU HAVE NITHING TO EAT OR DRINK FOR **SIX (6) HOURS** BEOFORE HAVING YOUR ANESTHETIC. IF YOU DO NOT FOLLOW THIS RULE, IT **IS VERY DANGEROUS AND MAY BE LIFE THREATENING!**

D. However, it is important that you take any of your regular medicines (high blood pressure, antibiotics, etc.) or medicines given to you by us, **using only a small sip of water.**

CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before I signed this form.

BEFORE SIGNING, PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

_____
Patient's (or Legal Guardian's) Signature Date

_____
Doctors Signature Date

_____
Witness' Signature Date