



# INFORMED CONSENT FOR ENDODONTICS

## A. IDENTIFICATION

I, \_\_\_\_\_ willingly agree to the following procedure:  
*(Print your full name)*

## B. STATEMENT OF REQUEST

1. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. Such complications may involve, but are not inclusive to:

- Infection, bleeding, numbness, tissue tenderness, teeth sensitivity, changes in tissue appearance, loss of tissue height, exposed roots, perforation of the tooth root, loss of teeth, damage to adjacent structures, damage to the existing restoration, broken instrumentation in the canal space, jaw or joint soreness (TMD) and changes in fit of partials or dentures.

I acknowledge that the treatment is a Biologic Procedure and that no guarantees have been made to me concerning the results of the operation or procedure. It is our sincere goal to provide the best possible treatment. I understand the success rate of a properly performed root canal procedure to be 75-80%. I understand the nature of the operation or procedure to be:

- Preventing or taking out decay and/or infection, taking out an injured or dead nerve, sealing the tooth roots and then preparing the tooth for a crown via a temporary or permanent filling.
- The teeth that these procedures will be performed on are located in the area of:  
Upper / Lower *(Circle appropriate one(s))*  
Front / Back *(Circle appropriate one(s))*  
Left / Center / Right *(Circle appropriate one(s))*

This procedure will be performed under the direction of Dr. \_\_\_\_\_.

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the above-named dental facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the above named facility. I understand that with the administration of such anesthesia numbness will occur to my face and lips. During this time care must be taken not to aggressively touch these areas and care must be taken when eating or trauma will result to these structures.

## C. SIGNATURES

**1. COUNSELING DENTIST/PROFESSIONAL: I have counseled this patient as to the nature of the proposed procedure(s), attendant risk involved, and expected results, as described above.**

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<b>Signature of Counseling Dentist/Professional</b>	<b>Date and Time</b>
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**2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, described above.**

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<b>Signature of Patient or Legal Guardian</b>	<b>Date and Time</b>
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<b>Signature of Witness</b>	<b>Date and Time</b>
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