Endodontic Consent for Treatment

Patient Name Date

If you have any question, please ask your doctor BEFORE signing.

What you are being asked to sign is your acknowledgment that you understand the nature of the proposed treatment, the known risks associated with it and the possible alternative treatments.

I hereby Authorize Dr. Karapanou and assistants to treat the condition(s) described below: _____
_____.

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: _____
_____.

I have been informed of possible alternate methods of treatment (if any), including: _____
_____.

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
B. Sensitivity
C. Bleeding
D. Pain
E. Infection
F. Numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent
G. Reactions to injections
H. Changes in occlusion (biting)
I. Jaw muscle cramps and spasm
J. Temporomandibular joint difficulty
K. Loosening of teeth crowns or bridges
L. Referred pain to ear, neck and head
M. Delayed healing
N. Sinus perforations
O. Treatment failure
P. Complications resulting from the use of dental instruments (broken instruments—perforation of tooth, root, sinus), medications, anesthetics and injections
Q. Discoloration of the face
R. Reactions to medications causing drowsiness and lack of coordination

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It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

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

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

INFORMATION FOR FEMALE PATIENTS

I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my signature.

_____

Patient's (Parent/Guardian's) Signature Date

_____

Doctor's Signature Date