Informed Consent for Dental Treatment

Please read this form, you will be asked to sign it after treatment discussion with the doctor. Thank you!

Endodontists are dental specialists with advanced training in endodontic (root canal therapy) procedures, which include routine as well as complex surgical and non-surgical procedures. Treatment provided in this practice is performed in accordance with the American Association of Endodontists and the ADA. Our mission is to provide endodontic treatment that is to or higher than the standard of care.

Root Canal Therapy procedure requires making an opening through the chewing surface of the tooth, removing the pulp tissue, and filling & sealing the space with an inert rubbery material called gutta percha and dental cement. Following root canal treatment, the tooth will require a final restoration, usually a crown. The final restoration is not part of this discussion. The intended benefit of this treatment is to relieve current symptoms and to retain the tooth root in the mouth. Treatment may require multiple visits, usually no more than two.

I understand that I will be given a local anesthetic injection and that in rare instances patients may have an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection, elevated blood pressure. I understand the injection areas may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

While serious complications are rare, there are inherent risks of endodontic treatment it is necessary to inform you of: pain, swelling, bleeding, changes in the bite, loss of dental restorations, infection, separation (breakage) of root canal instruments, perforation of the tooth, soft tissue injury, sinus involvement, and nerve disturbances such as temporary or permanent numbness, itching, burning or tingling of the lip, chin, teeth, or mouth tissues, side effects or reactions to medications, jaw and muscle stiffness, transient limited opening and TMJ involvement (occasionally requires treatment by TMD specialist). These complications may result in the need for further treatment of a dental or surgical nature and/or loss of the tooth. A separated instrument may be sealed in the tooth, which may lessen the chance for clinical success. In unusual cases hospitalization or intra-venous (I.V.) antibiotics or sedation may be necessary to treat an endodontic infection. Increase in heart rate and blood pressure might occur as a reaction to the local anesthetics (numbing medications) and/or infection with the further required medical treatment (outpatient or inpatient).

Alternatives to endodontic treatment include extraction, or no treatment. These alternatives imply consequences including the need to replace missing teeth, continued or worsening infection and pain, and possible spread of infection to other areas of the body with serious health consequences.

I have provided complete and accurate medical and personal history, including current medications, prescription and nonprescription, which I take, and any known drug allergies. I will follow all instructions as explained to me, and will permit recommended diagnostic procedures, including X-rays. I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

It is the patient's responsibility to contact this office for recommended follow up after completion of the root canal treatment (first follow up should be usually at 6 months) as well as in cases of any complications, including but not limited to swelling, pain, numbness or bruising.

I have been given the opportunity to ask questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. By signing this document, I am freely giving my consent to allow and authorize Dr. Berman and staff to render any treatment necessary to my dental condition, including prescribing and administering any and all anesthetics and medications.

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

_______________________________                  ____________
patient or guardian                        date

_______________________________                  ____________
treating dentist                        date

_______________________________                  ____________
witness                        date

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