Nona I. Breeland, D.D.S., M.S.
Practice Limited to Endodontics

ENDODONTIC THERAPY CONSENT FORM

_____ has been advised by Dr. Breeland to have endodontic therapy (Root canal treatment/ Endodontic retreatment) on tooth number(s) _____.

Root canal treatment is an attempt to save a tooth which otherwise may require extraction. It should be a very positive experience. While you may be nervous about the treatment, my staff and I will explain the need for treatment, the procedures involved, and give post-operative instructions concerning your comfort. Success of treatment is dependent on many variables, which are not under the control of the dentist or patient. Root canal therapy is reportedly successful 85-95% of the time.

It is important that you know the complications, which can occur during treatment, which may affect the outcome of treatment. Such complications include, but are not limited to:

1. **Post-operative discomfort lasting a few hours to several days which may require pain relieving medications as deemed necessary by the dentist.**

2. **Post-operative swelling of the surrounding gum tissue or facial area, which may require antibiotic medications as, deemed necessary by the dentist.**

3. **Separation of canal instruments in the canal which may, in the judgment of the dentist, be left in the canal or require surgery for removal.**

4. **Perforation of the tooth/root, which may require additional surgical correction or result in loss of the tooth.**

5. **Crack or fracture of tooth/restoration (porcelain restorations especially) during treatment, which may require a new restoration or possibly result in loss of the tooth.**

6. **Complications associated with the administration of local anesthetics including allergic reaction, fainting, heart palpitations, bruising, and hematoma.**

7. **Short or long-term tenderness or soreness related to the temporomandibular joint (jaw joint).**

Once the treatment is completed, you should return to your dentist for definitive restoration of the tooth within (two to eight) weeks after treatment. If you continue to have symptoms with the tooth, please contact our office for further instructions. Periodic recalls may be recommended. Please contact our office to schedule recall appointments at the time determined by Dr. Breeland.

The goal of this office is to provide the best endodontic care for you in a secure caring environment. Your comfort is our main consideration. I trust that the experience in our office will be satisfying.

Please sign and date this form indicating that you have read and understand the information.
If you have questions about treatment, please ask Dr. Breeland.

I GIVE MY PERMISSION FOR DR. BREELAND TO PERFORM THE ABOVE DESCRIBED ENDODONTIC PROCEDURE.

_____ _____
Patient signature (Parent/Guardian) Date

_____ _____
Dentist signature Date

_____ _____
Witness signature Date