

Flatirons Endodontics, LLC
Brian C Frutchey, DMD

Consent For Endodontic Therapy

Please review the following consent. You will be required to sign it prior to the initiation of treatment.

This is my consent to receive endodontic therapy. I further give my consent to the doctors to take any x-rays, administer any medications, anesthetics, drugs, and services or procedures that they deem necessary or advisable as a corollary to the planned endodontic treatment.

I understand that endodontic therapy is a procedure to retain a tooth that may otherwise require extraction and that as a specialty office, only endodontic therapy and associated procedures are performed here. Endodontic therapy results in the removal of the pulp tissue (nerves and blood vessels) from the inside of the tooth, then seals the space with a filling material. Endodontic therapy enjoys a high degree of success, but because it is a biological procedure, success cannot be guaranteed or warranted. Occasionally, a tooth which has had endodontic treatment may require retreatment, periradicular surgery, or even extraction. During treatment there is a possibility of instrument separation within the tooth, perforation of tooth structure in gaining access to the canals, and fracturing of the tooth itself. Following treatment, the tooth must be restored to function with a protective restoration, usually a post and crown. Some teeth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices include but are not limited to pain, swelling, loss of tooth, infection, and spread of infection to other areas.

Complication of endodontic therapy and anesthesia may include swelling, pain, Trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness of the lip, gum, or tongue, which is rarely protracted, and even more rarely permanent.

The nature of endodontic therapy had been explained to me. I have had the opportunity to have my questions answered to my satisfaction by the doctor concerning the nature of treatment.

Tooth/Teeth #(s)

Patient Name (please print)

Date

Patient Signature (Guardian if patient is a minor)

Doctor's Signature