vanendo
Certified Specialists in Endodontics

Endodontic Treatment Consent Form

I hereby authorize the endodontist at VanEndo clinic to treat the endodontic disease/infection.

Tooth / teeth Number(s): _____ **Cost estimate: $**_____

Procedure: ☐ **Non Surgical Root canal Treatment** ☐ **Surgical Endodontic**

The diagnosis and procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the endodontic procedure(s).

There are certain inherent and potential risks, however uncommon, in any treatment plan or procedures. I understand that the following may be inherent or potential risks for the treatment I will receive:

swelling, sensitivity, bleeding, pain, infection, numbness and/or tingling or burning sensation in the lip, tongue, chin, gums, cheeks and teeth (which is transient but rarely may be permanent), reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasm, TMJ difficulty, loosening of teeth, crowns or bridges, referred pain to ear, neck and head, delayed healing, sinus perforations, treatment failure, complications resulting from the use of dental instruments (broken instruments-perforation of tooth, root, sinus), medications, anesthetic and injections, hematoma, and reactions to medications causing drowsiness and lack of coordination, possible neuropathic pain, risk of MRONJ (if applicable). In case of traumatic dental injuries, I understand that the short term and long term complications are unpredictable, and despite appropriate treatment, the tooth may not heal predictably.

I understand that in spite of all efforts, this tooth may require further endodontic interventions, or perhaps extraction in the future.

I have been informed of possible alternative methods of treatment including no treatment at all with risks and benefits.

I have been given the opportunity to question the endodontist concerning the material presented in this form, 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.

Patient's Name: _____ **Signature:** _____ **Date:** _____
(Parent/Guardian)

Office Staff: _____ **Signature:** _____ **Date:** _____

Endodontist: _____