INFORMED CONSENT FOR ROOT CANAL (ENDODONTIC) TREATMENT

After careful oral examination, the treating dentist at Advanced Dental Services of Jacksonville has advised me that root canal treatment is required. I hereby give consent to Dr. Andrew Maples and/or Dr. Brian Maples to complete this recommended treatment.

The treating dentist has explained to me the nature and purpose, method and manner of the proposed treatment. The treating dentist has explained the benefits and complications along with the desirability of root canal treatment compared to extraction or other alternatives. The treating dentist has also explained the consequences of not having the root canal treatment completed. The risks discussed include, but are not limited to the following:

- Varying degrees of postoperative discomfort lasting 2-3 days or in some instances longer.
- Swelling of the gum area in the vicinity of the treated tooth.
- Infection.
- Trismus (restricted jaw opening).
- Separation of the root canal instrument which may either be left in the treated root canal or require additional treatment for removal. This has the potential to cause an increased likelihood of root canal failure in the future.
- Failure rates of 5-10%. If failure occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.
- Perforation of the root canal which may require corrective surgery or result in premature tooth loss or extraction.
- Premature tooth loss due to progressive periodontal (gum) disease in the surrounding area.
- Failure to place a permanent restoration within a reasonable period of time may increase the likelihood of failure possibly requiring retreatment or tooth loss.
- Under-fill or Over-fill of the root canal filling material which may necessitate retreatment, root-end surgery, and in extreme cases tooth loss.

I understand that following root canal treatment, my tooth will be brittle and must be protected against fracture by placement of a permanent restoration.

I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional procedures which the above-named dentist may consider necessary.

The practice of dentistry is not an exact science. Although good results are expected, I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure. Longevity of the tooth depends on many factors, some of which include: the complexity of the root canal system within the root, oral home care, and placement of a permanent restoration. Due to individual patient differences, there is always a risk of failure, need for more treatment, or worsening of my present condition despite careful treatment.

The benefits, risks, and complications associated with local anesthesia and sedation have been thoroughly reviewed with me. The risks discussed include, but are not limited to: partial or complete paralysis of facial nerve(s), hematoma (a swelling that contains blood), fracturing of the anesthetic needle, temporary or permanent numbness, allergic reaction, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac conditions, decreased heart rate, and depressed breathing. If applicable, I will arrange for someone to drive me home from the office after I have received oral sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I confirm that I have read and fully understand the above and I agree to cooperate completely with the doctor's recommendations while receiving care at Advanced Dental Services of Jacksonville.

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PRINTED NAME	SIGNATURE	DATE