BEACH ENDODONTICS

SPECIALISTS IN ENDODONTICS

INFORMED CONSENT FOR ENDODONTIC PROCEDURES

Endodontic treatment or retreatment involves, but is not limited to, the removal and treatment of the contaminated/infected root canal material. Alternative treatment options may include no treatment or tooth extraction with or without replacement. Risks & complications from endodontic treatment and retreatment may include, but are not limited to, transient pain/swelling, inability to treat blocked or calcified canals, instrument separation and/or a persistent disease state that, any of which, may require future endodontic surgery or extraction. In some cases, access to the root canals will require drilling through existing crowns or bridges. While unlikely, this process may cause irreparable damage to the crown or bridge such that replacement of the crown or bridge may be needed. Endodontic treatment may be the only possible option to treat the disease and save your natural tooth. Although endodontic treatment is science-based and has a very high degree of clinical success, it is a biological procedure with results that cannot be guaranteed. I acknowledge that no guarantee has been offered as to the outcome that may be obtained. Occasionally, a tooth that has had root canal treatment or retreatment may require further treatment such as surgery or even extraction. I also understand that endodontic treatment or retreatment is performed at this office. Restoration of my tooth after completion of endodontic treatment (filling, crown, etc.) is usually performed by my family dentist. However, when applicable, we will try to place the definitive restoration unless a new crown or bridge is needed. Lack of proper restoration of the tooth may result in damage and/or loss of the tooth. I understand that it is my responsibility to ensure that my tooth is properly restored. **My treatment options have been explained to me as well as the indications and possible complications of endodontic treatment and I offer my consent for treatment.**

All signatures must be by a parent or guardian if patient is under the age of 18.

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Patient Name (Printed)

_____ _____

Patient Signature **Date**