Endodontic Associates of Greater Waterbury, PC

INFORMED CONSENT

I understand that I have been referred to Endodontic Associates of Greater Waterbury for diagnosis, evaluation and conventional root canal treatment of tooth #_____

I have been given the following information regarding this treatment:
This diagnosis as relates to this tooth is _____

This treatment involves but is not limited to removing the diseased pulp tissue (blood vessels and nerves) from the root canals and sealing the space with a biologically inert filling material. It is very important to have the tooth properly restored as soon as possible after the root canal treatment to prevent fracture and contamination of the roots. At the time of diagnosis any negative factors that may affect the long term outcome of the tooth will be discussed. Also, all the risks, benefits, and alternative treatments will be discussed.

Treatment may take up to several visits and post operative discomfort and swelling can occur. Occasionally, unforeseen clinical findings and procedural problems may be encountered after treatment has begun. These include but are not limited to obstructed canals, cracks, resorptive processes, perforations, separated instruments, and fracture of porcelain crowns. The significance of these findings will be discussed at the time of discovery.

Unless stated otherwise, the long term outlook for the treated tooth is very good, provided that it is properly restored and remains free of decay and periodontal disease.

Despite optimal care, a very small percentage of endodontically treated teeth show an area of inflammation around the root tip when examined at the one year post op visit. If this occurs, we may want to observe the tooth for an additional year or discuss other options. These options could include retreatment or possible surgical intervention (apicoectomy).

I have read and understand the information provided to me both in written form as well as verbally regarding the treatment of tooth #_____. I have discussed options with the doctor including no treatment, non surgical endodontic treatment or extraction along with risks and benefits.

I give my permission to have this treatment performed.

Patient's Name_____Date_____

Patient's Signature_____ Doctor's Signature_____