HILLTOP DENTAL

Hilltop Dental Associates, P.C.

1736 Lyter Drive
Johnstown, PA 15905
Office: (814) 255-6831
Fax: (814) 254-1521
SrokaDental.com

Gary A. Minchau, D.M.D. Matthew R. Sroka, D.M.D.

Endodontic Consent/Information Form

We would like to inform our patients about the various procedures involved in endodontic therapy and to have their consent prior to starting treatment. Endodontic, or root canal, therapy is done in order to save a tooth which otherwise might need to be removed. The following explains possible risks that may occur from root canal therapy treatment.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections. These complications include (but are not limited to) swelling, sensitivity: bleeding, pain, infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth. These symptoms may be transient but on infrequent occasions may be permanent: reaction from injections; changes in occlusal (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include, but are not limited to: the possibility of instruments broken within root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals; and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: In most treatment cases, no medication is required other than over-the-counter pain medications (ibuprofen preferably) to alleviate soreness; however, in some cases, an antibiotic regimen or prescribed pain medication may be necessary. Please be aware that prescribed medications may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until totally recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of the minor named) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return for a permanent restoration of the tooth involved, such as a crown, cap, inlay, or filling.

I understand that root canal treatment is an attempt to save a tooth which, may otherwise require extraction, and may also require retreatment, surgery, or even extraction in the future.

Patient (Print Name) _____

Signature of Patient/Parent _____ Date _____