**Barry A. Kaplan, DMD**

**301 Belleville Avenue**

**Bloomfield, NJ 07003**

**(973)743-3825**

**INFORMED CONENT FOR ENDODONTIC (ROOT CANAL) THERAPY**

**Please review the following consent form. You are required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.**

Endodontic therapy involves removal of the softer center potion of the tooth called the pulp with small metal instruments through an access created in the top portion of the tooth (crown). The resulting space inside the center portion of your tooth is filled to seal the root canal. The root(s) of the tooth remain to anchor the tooth in your jawbone. The purpose of this treatment is to treat and possibly maintain my diseased tooth and/or tissues in my mouth that would have been otherwise extracted or lost. Sometimes, root canal therapy may need additional management, such as retreatment or surgery. The fee quoted is for the current endodontic (root canal) therapy only; and not for the final restoration (filing, crown, etc.) nor any future treatment or surgery that may become necessary.

I understand there are **alternatives to endodontic (root canal) therapy.** They include but may not be limited to:

* No treatment at all. My present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to: worsening of the disease, infection, pain, swelling, cyst formation, loss of supporting bone around my teeth, premature loss of tooth/teeth and/or other systemic disease manifestations and serious infection that spreads throughout the body..
* Definitive diagnosis can be difficult and waiting until more signs/symptoms develop may be recommended.
* Extraction of the infected tooth (teeth) with nothing to fill the space. This may result in: shifting of teeth, change in bite, periodontal disease.
* Extraction of the infected tooth (teeth) followed by a bridge, partial denture, or implant to fill the space.
* In the case of Retreatment (of previous unsuccessful endodontic therapy), endodontic surgery may also be an option.

I understand that this is an elective procedure and there are certain **potential risks and complications arising from the root canal treatment** thatmay include, but not be limited to, the following:

* Postoperative discomfort or sensitivity. This could include but is not limited to pain in the ear, neck, and head. The pain and/or sensitivity usually lasting a few hours to several days and sometimes longer. This discomfort or sensitivity may radiate to other areas, with intensity from slight to extreme. Most commonly the tooth is temporarily sensitive to biting.
* Complications resulting from use of instruments, materials, medications, anesthetics, and injections. This includes altered sensation (tingling or numbness) of the tongue, lip, chin, cheek, gums, which is very rare and usually temporary, but may be permanent.
* Damage to the nerve in the lower jaw that may cause temporary or permanent numbness. Due to the proximity of the roots of the lower teeth to the nerve of feeling in the lower lip, teeth, and gums, it is possible to bruise or damage the nerve during root canal instrumentation, heat from the root canal filling material, extrusion of root canal filling material out of the bottom of the tooth, preoperative, or postoperative swelling. The affected area of the lip, gums, teeth, or chin could feel numb, tingly, heavy, or have burning sensation. Many times full sensation returns to the area, but it may take a year or more. If this complication arises, you will be closely monitored to see if sensation is returning to the area. You may require a referral to a nerve specialist. Any fees resulting from the referral are the responsibility of the patient.
* Postoperative swelling, bleeding, pain &infection in the vicinity of the treated tooth, facial swelling, and/or discoloration of tissues which may persist for several days or longer. Occasionally a small incision to drain the swelling is required.
* Vomiting, allergic reactions, delayed healing and sinus perforations.
* Restrictive mouth opening (trismus), jaw muscle spasm, jaw muscle cramps, temporomandibular joint difficulty, or change in bite and the way teeth fit together, which occurs infrequently and usually lasts for several days but may last longer.
* Failure rate of approximately 5-10% under optimal conditions. If failure occurs, additional treatment will be required such as: retreatment, endodontic surgery or extraction of the affected tooth. Retreatment (of previous, unsuccessful endodontic therapy) failure rates are higher, but vary due to suspected reason for failure.
* The instruments used during the procedure may unavoidably cause loss or injury to adjacent teeth or dental restorations and soft tissue. This could include but is not limited to damage to bridges, existing fillings, crowns and veneers. The patient is responsible for all fees related to any such loss or injury.
* Accidental swallowing of foreign matter.
* If your tooth already has an existing crown, there is a possibility that it will need to be replaced due to undiagnosed internal decay or loss of structural support. Crowns with white exterior are at a slightly higher risk of fracturing when we create an opening on the biting surface for treatment.
* Loss of tooth structure in gaining access to canals and fractured teeth.
* With some teeth, conventional endodontic (root canal) therapy alone may not be sufficient and additional treatment may be required. This treatment may require referral to an endodontist or additional procedures to be performed by Dr. Kaplan. The patient is responsible for all fees related to additional required procedures. Examples are:
1. Significant overfills or underfills of the filling materials.
2. If the canal(s) are severely bent, calcified/blocked, split or other condition which prevents complete treatment. This may require endodontic surgery or extraction of the tooth.
3. If an endodontic instrument separates (breaks) in the tooth during treatment. In the judgment of the doctor, he my leave the broken instrument in the tooth or attempt to remove it. Surgery at the bottom of the root may be required for successful completion of the case or the tooth may have to be extracted.
4. Premature tooth loss due to progressive periodontal (gum) disease and/or loosening of the tooth.
5. Periodontal treatment may be needed.
6. Root fracture is one of the main reasons why root canal treatment fails. Unfortunately, some cracks that extend from the crown down into the roots are invisible and undetectable. They can occur on uncrowned teeth from traumatic injury, biting on hard objects, and habitual clenching or grinding, and even just normal wear and tear. It is almost impossible to determine if the root fracture occurred before or after root canal therapy. Whether the root fracture occur before or after the root canal, it will probably still require extraction. In some teeth with multiple roots, the affected root can be removed (hemisection or root amputation) and the rest of the tooth left in place. If any of these procedures (extraction, hemisection, root amputation) are necessary, any fees associated with them are the responsibility of the patient. In some cases the patient may need to be referred to a specialist to perform the necessary treatment. Once again the patient is responsible for all fees associated with the referral.
7. Preforation of the root tooth or sinus. Perforation of the root canal with instrument which may require additional surgical corrective treatment or result in premature tooth loss or extraction. Repair of the perforation may require referral to an endodontist.
8. Persistent infections requiring endodontic surgery or extraction of the tooth.
9. Missed canals

 In some cases, follow-up visits may be recommended while in others an endodontic

 surgical procedure, extraction, or other treatment may be required to resolve the problem.

 The doctor will explain the options available. I understand that I will be responsible fees

 relating to any and all complication that may develop.

* Internal or external resorption-The tooth dissolves itself. This is seen within five years in almost 100% of the cases where the tooth as been avulsed (knocked out or severely displaced). This can also be seen in other cases of trauma. Seldom does it occur in cases where trauma is not a factor. If the tooth begins to dissolve itself the tooth must be extracted.
* During the instrumentation of the tooth, a procedural error may occur. Although this occurs rarely, such an occurrence could cause failure of the root canal, loss of the tooth, or possibly the need for a new crown or restoration.
* Diabetic patient’s w/apical lesions have an impaired healing potential vs. healthy patients regardless of how well the root canal treatment is done.
* Despite the high success rate of this procedure, there is a chance that the root canal procedure will not resolve your pain. In such cases, additional treatment may be necessary resulting in additional charge to you. Examples of other treatment include retreatment, root tip surgery, or even extraction.

**Acknowledgment:** I acknowledge:

1. I have the option of being treated by an endodontist (root canal specialist). Please advise us if you would like to be referred to an endodontist.
2. Unforeseen conditions may arise that require a procedure that is different than set forth above or a referral to a specialist. I authorize Dr. Kaplan to perform such procedures when, in his professional judgment, the procedures are necessary.
3. If a root canal treatment cannot be completed due to a complication, there will be a charge for all procedures performed up to that point. There will be a charge for all completed cases regardless of success or failure. There will be a charge for any additional treatment required for this tooth.
4. That it is the patient’s responsibility to tell Dr. Kaplan about any pertinent medical condition(s) I have, known allergies and report any changes in medical history.
5. (especially to medications or sulfites) any medications I am taking including over the counter medications such as aspirin, nutritional supplements and/or herbs.
6. That I may have to take certain medications (drugs) while this therapy is being performed which may result in allergic reactions, drowsiness or lack of awareness and coordination. I understand that I am not to use alcohol, tranquilizers, or sedatives while on medication for my treatment unless otherwise instructed by my doctor. I understand that I am not to operate a car, or other machines, while taking certain medications as indicated by Dr. Kaplan. I further understand that drugs and anesthetics may cause unanticipated reactions which may require medical treatment. **Females Only:** Antibiotics may interfere with the effectiveness of oral contraceptives. (birth control pills). Therefore, I understand that I will need to use some additional form of birth control.
7. Endodontic therapy can require one to several appointments depending on degree of infection/inflammation and degree of treatment difficulty. It is important that you maintain scheduled appointments otherwise complications may arise.
8. Abide by the specific instructions given.
9. Once a tooth has received root canal treatment, it tends to be more brittle and week. Temporary fillings are usually placed in the tooth after root canal treatment. I understand that upon completion of the root canal therapy, it is my responsibility to have a final restoration placed on the endodontically treated tooth to prevent fracture. Examples of restorations include filling, crown (may also include crown build-up and/or post & core), onlay, bridge etc. I realize that should I neglect to return to Dr. Kaplan for the proper restoration within one month or sooner as directed by the doctor, there is an increased risk of 1) failure of the endodontic therapy, 2) fracture of the tooth and/or,3)premature loss of the tooth. Our fee only includes a temporary filling, unless otherwise stated. The fee for the crown, crown build-up, post and core, filling, bridge onlay or any other restoration will be the responsibility of the patient. On rare occasions, the tooth can fracture in spite of being restored.
10. See Dr. Kaplan for routine dental care every six months. The purpose of this is to monitor the endodontic treatment for healing and recommend further treatment as may be needed. If I do nothing, pain, severe abscess or disabling infection can result. Teeth treated with endodontic therapy can still decay. As with other teeth, the proper care of these teeth consists of good home care, sensible diet, and periodic check-ups.

**No Warranty or Guarantee:** I acknowledge no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result. There is a risk of failure, and complications such as those listed above, despite the best of care.

**Informed consent:**

 I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this endodontic therapy, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling Dr. Kaplan of any pertinent medical conditions and prescription and non-prescription medications. I have had an opportunity to ask questions and have received answers to my satisfaction. I also understand that any questions that I might have during treatment will be answered when I ask them. I voluntarily assume any and all possible risk of substantial harm, if any, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service is **$\_\_\_\_\_\_\_** and has been explained to me and is satisfactory. I understand that I will be responsible for fees relating to any and all complication that may develop. By signing this form, I am freely giving my consent to the performance of the endodontic therapy as presented to me during my consultation and as described in this document above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Kaplan. I have read and understood this document before I signed it.

\_\_\_\_I give my consent for the proposed procedures as described above.

\_\_\_\_I refuse to give my consent for the proposed procedures as described above. I have been informed of the potential consequences of my decision to refuse this treatment.

Patient Name:

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 Patient’s Signature Date

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