Rhode Island Endodontics
Usman Fazli, DMD
Diplomate, American Board of Endodontics
Fellow of Royal College of Dentists Canada

# Root Canal Informed Consent

| PATIENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| First Name | | Last Name | | Birth Date | |

INFORMED CONSENT FOR ROOT CANAL TREATMENT on Tooth/Teeth# _____

1. Recommended Treatment

I hereby give consent to Dr. Usman Fazli to perform a Root Canal Procedure based on findings made during the initial evaluation of the tooth.

Root Canal Procedure is removal of dental pulp and disinfection of the pulp space from within the tooth, followed by a root filling. Local Anesthetic is administered and dental dam is placed prior to the start of procedure. Intraoral radiographs, before, during and after completion of the procedure are taken to assess progress. The procedure may be completed in one or multiple visits depending upon recommendations made by Doctor. The visits are scheduled between 60-90 minutes.

2. Alternative Treatment Options

You have the option to decline treatment or choose extraction (complete removal) of the tooth. If you choose no treatment, there is possibility of developing a spreading dental infection (cellulitis) or Acute Dento-alveolar abscess (infection spreading in the jaw bone) that can spread to multiple fascial spaces on face, neck, sinuses and can be life threatening.

3. Understanding Anatomy and Procedure

Root Canal Procedures are recommended based upon many factors affecting the dental pulp:

a. Caries/decay extending deep into tooth
b. Large fillings/restorations deep into dentin close to pulp. Disintegrating fillings with recurrent caries/decay close to the pulp
c. Cracks in natural teeth or teeth restorations that extend deep into the tooth
d. Recommended as a preventative measure for a tooth that is planned to get a permanent restoration such as a crown or bridge.

An inflamed, diseased or infected pulp often has symptoms associated with the tooth such as hot and cold sensitivity that reacts with intense symptoms; lingering pain/throbbing pain or inability to chew on the tooth. Alternatively, you could have a small area of infection visualized as a dark shadow on the end of the root on routine radiograph taken that would indicate an infected tooth with no symptoms. Removal of this diseased pulp tissue and disinfection of the pulp space is recommended to prevent disease progression from the tooth into the jaw bone known as Periapical periodontitis.

The Dental pulp (neurovascular tissue) is encased in the tooth in a hollow space that courses from the crown portion of the tooth (visible in your mouth) and exits at the end of the root in the jaw bone. Periapical Radiographs and CBCT scan is taken to visualize the dental pulp space in the tooth. The Dental pulp has numerous branches in the root and its anatomy and curvature has numerous variations. It also forms calcifications throughout the course of its biological life and these calcifications can cause significant obstructions. The operator attempts to navigate the space occupied by the pulp and then enlarge it to allow chemical disinfection of the space. This is accomplished by small flexible instruments

(dental files) that are used by hand and rotary engine driven files. Successful navigation of the dental pulp space is dependent upon the geometry and curvature of the space. Heavily calcified/ obstructed or obscured branching of the space may not allow the file to enter and shape the root canal space for adequate disinfection. The goal of treatment is to reduce the bacterial contamination of the space to levels that allow the body to heal the tissues that are inflamed or infected. Root Canals are not guaranteed for success as immune system and the virulence of micro-organisms play a big role in outcomes of success. Certain bacterial species are resistant to chemical disinfection and continue to cause disease despite the best effort in performing the root canal. Although rare, but this is one of the reasons **no guarantees of success can be given for the procedure**.

_____ *Patient Initials*

4. Risks Specific to Endodontic Therapy

Those risks include the possibility of instruments broken within the root canals, perforation(s) (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals, and cracked teeth.

During treatment complications may be discovered which make treatment impossible, or which may require endodontic surgery or extraction. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcification(s), broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the root and resorption. Broken instrument removal, retreatment or post removal may cause damage to the root/tooth structure.

_____ *Patient Initials*

5. Other Risks of Treatment including Local Anesthetics and Medications

As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent. Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be worsened by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

_____ *Patient Initials*

**CONSENT**

I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures deemed advisable in the opinion of the doctor.

**I also understand that upon completion of root canal therapy in this office I shall return to my referring and/or regular dentist for a permanent restoration of the tooth involved. This restoration may be a crown (cap), jacket, onlay or filling. We recommend placement of permanent restoration within 30 days of completion of root canal treatment.**

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. **Although root canal therapy has a high degree of success, it cannot be guaranteed.** Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction. I understand that I am responsible for treatment failure if my tooth is not permanently restored in a timely manner (typically one month). I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

**I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.**

## FORM COMPLETION

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|---|---|---|---|
| **Signature of** | ❑ Patient<br>❑ Legal Guardian | ❑ Parent<br>❑ Agent Under Durable Power of Attorney | |
| **Printed Name** | *First Name* | *Last Name* | |
| **Signature of Patient, Parent or Guardian** | | **Date** | |
| **Witness Signature** | | | |
| **Witness Printed Name** | | | |
| **Provider Signature** | | | |