TREY PETTY ORAL HEALTH
Compassionate Care

Trey Petty Oral Health
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PATIENT AGREEMENT AND INFORMED CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Patient Name: _____ **Date:** _____

This Patient Agreement contains important information about your planned endodontic procedures(s). BY SIGNING THIS PATIENT AGREEMENT, YOU ACKNOWLEDGE THAT YOU HAVE READ AND AGREE TO ALL OF THE TERMS AND CONDITIONS IT CONTAINS. Please read carefully and ask questions about any areas that are unclear:

Dr. Petty recommends the following endodontic procedure(s):

_____

I have reviewed the written and visual information provided to me.

Dr. Petty and/or his staff have explained to me the proposed treatment. I understand that there are other alternatives to root canal treatment. They include, but may not be limited to:

1) No treatment: The risks of no treatment include pain, infection, swelling, need for antibiotics, and/or loss of bone around the tooth and adjacent healthy teeth, all of which may result in the premature loss of the tooth or teeth.

2) Extraction (pulling the tooth out) with nothing to fill the space created: This may result in shifting of remaining teeth, change in my bite, bone loss in the area, and/or jaw (tempormandibular) joint problems.

3) Extraction followed by a bridge, partial denture, or implant to fill the space created.

4) Referral to an endodontist (root canal specialist).

I understand that there are certain potential risks and complications with the recommended endodontic procedures, anesthesia (freezing), chemicals and proposed drugs that may be used/ recommended/prescribed to me.

These include, but are not limited to:

1) POST-TREATMENT PAIN: Can be controlled by the medication that Dr. Petty recommends (e.g. Advil/Motrin [ibuprofen] or Tylenol [acetaminophen] - please read the package insert for dosages) or prescribes. These medications when taken on an empty stomach can cause stomach upset, nausea, etc. Please try to take your pain medication with food or fluids.

2) SWELLING, BLEEDING

3) INFECTION: May occur during or after completion of the procedure. No matter how carefully sterility is maintained, it is possible to develop an infection. This is because my mouth is a non-sterile environment. The infection may require the use of antibiotics and/or surgical drainage. Should severe swelling occur, especially if accompanied by fever/temperature or malaise, please call Dr.Petty's office as soon as possible. If difficulty swallowing or breathing occurs, go to a hospital immediately.

4) DAMAGE TO NERVES: May result in temporary (weeks/months/up to a year) or permanent numbness or tingling (extremely rare) to the lower lip, tongue, gums and/or chin. It can result from the root canal procedure or administration of the anesthetic (numbing/freezing).

5) SINUS INVOLVEMENT: In some rare cases, the root tips of the upper teeth lie very close to the sinuses and may become involved in the infection and/or swelling.

6) RESTORATION DAMAGE: When a root canal treatment needs to be performed through a crown (cap) or large filling, the porcelain or filling material may fracture or loosen, or a cavity might be found underneath. This may require replacement of the crown or restoration.

7) INJURY TO ADJACENT TEETH, FILLINGS AND/OR SOFT TISSUE: This can occur no matter how carefully the endodontic procedures are performed.

8) UNUSUAL REACTIONS TO MEDICATIONS GIVEN OR PRESCRIBED: Mild to severe reactions, may occur from the anesthetics (numbing/freezing) or other medications administered, recommended or prescribed. Prescription drugs must be taken according to the instructions. Women who are using oral contraceptives should use another form of birth control, as antibiotics can render these contraceptives ineffective.

9) BROKEN (SEPARATED) INSTRUMENT IN THE ROOT CANAL SPACE: Extreme care will be used, however, it is possible that an instrument may separate or break in my tooth during the procedure. This may require retrieval and possible referral to a root canal specialist (endodontist). Dependent upon where the instrument breaks, it may be possible to leave it in place.

10) LIMITED MOUTH OPENING: A result of opening my mouth for an extended period of time. It may last for several days or weeks, with possible pain/clicking of the jaw joint.

11) PERFORATIONS (EXTRA OPENING), BLOCKAGES, INCOMPLETE HEALING: Perforations made by the instruments in the canal or blocked canals may result in incomplete healing, no matter how carefully the root canal treatment is performed.

12) THERE IS NO GUARANTEE TO THE RESULT OF MY ROOT CANAL TREATMENT: IT MAY FAIL**.**

I UNDERSTAND THAT THIS ROOT CANAL TREATMENT WILL NOT PREVENT FUTURE TOOTH DECAY OR FRACTURE, AND OCCASIONALLY, A TOOTH THAT HAS HAD A ROOT CANAL TREATMENT MAY REQUIRE RE-TREATMENT, SURGERY OR EXTRACTION (REMOVAL).

I UNDERSTAND THAT A FINAL CROWN (CAP) MUST BE DONE AFTER COMPLETION OF THE ROOT CANAL TREATMENT. THIS IS ESPECIALLY IMPORTANT FOR MY POSTERIOR (BACK) TEETH. IF MY TOOTH IS NOT COVERED WITH A CROWN, IT MAY FRACTURE AND NEED TO BE EXTRACTED (PULLED OUT). Please ask Dr. Petty about this statement if you have any concerns about restorations after root canal treatment.

I HAVE READ THIS PATIENT AGREEMENT AND INFORMED CONSENT. I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION AND I FULLY UNDERSTAND THE TERMS OF THIS AGREEMENT. I GIVE DR. PETTY PERMISSION TO DO THE ABOVE LISTED PROCEDURES.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____