

# PATIENT INFORMATION

CONFIDENTIAL

## ENDODONTIC RCT INFORMED CONSENT

### PLEASE READ CAREFULLY

I have been advised and understand that root canal treatment is a procedure to retain a tooth that otherwise may require extraction. A patient may experience some discomfort and swelling of the gum near the treated tooth and/or facial swelling which may last several hours and in some cases several days or longer. If deemed necessary the doctor will prescribe medication.

Although root canal treatment has a very high success rate, there is a 3-6% failure rate. Should additional treatment be needed, there will be additional costs involved above and beyond the original fee for root canal treatment. You will be informed of the fees and your estimated portion due of those fees prior to any additional treatment being performed.

Infection in the treated tooth can occur. Restriction of the jaw usually lasts several days or longer. Breakage of root canal instruments during the procedure may occur and upon the doctor's judgment the instrument may be left in the treated tooth or removed surgically. Perforation of the root canal with instruments may occur requiring additional corrective surgery or resulting in premature tooth loss or extraction. Due to trauma, inflammation, or chemicals, the patient may experience prolonged paresthesia (numbness).

Upon root canal treatment completion, a temporary filling will be placed in the tooth unless otherwise advised. For the best possible outcome of your treatment today, you must schedule an appointment to be seen by a general dentist to have the placement of a permanent restoration done and we recommend you be seen within the next 4-5 weeks. We understand your dentist may not be able to accommodate the above time frame and we require you to call our office should your appointment be scheduled beyond the suggested time frame as we are not responsible for the longevity of the treatment should final restoration not be completed within this suggested time frame and you fail to notify our office. Negligence in this matter could result in loss of the tooth.

I understand that I may need to return for a follow-up visit as indicated by Dr. Eric Gotlieb.

I understand there is no guarantee of success with root canal treatment and I attest that I have read the above information and fully understand that which the doctor has reviewed with me. Any and all of my questions have been answered and I consent to have this procedure.

I understand that this form will be saved in my patient record, and that I may have a copy of this signed form at my request.

Patient Name (PRINT) \_\_\_\_\_

Patient or Parent/Guardian Signature (SIGN) \_\_\_\_\_ Date \_\_\_\_\_