TOOTH/TEETH # _____

Dr. Alkhalil/Agolli has explained the benefits and risks of endodontic treatment to me. I fully understand that endodontic treatment involves the removal of tissues in the center of the tooth (root canal) and the sealing of the space that is created during the process of removal and cleansing of the root canal system.

I fully understand that there may be some unwanted complication(s) and unforeseen difficult circumstances during or after the treatment, some of which are listed below. **No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I fully understand that an alternative treatment may include; extraction of the involved tooth or teeth, waiting for more definitive symptoms. The risks of no-treatment include, but are not limited to: infection, swelling, cyst formation, pain, loss of tooth/teeth and /or systemic disease**. I fully understand all the following points below:

1- The purpose of the root canal therapy is to retain teeth that would otherwise have to be extracted.

2- Treatment is usually done in one visit but may require multiple visits.

3- Endodontic treatment has a high degree of success, however, I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the treatment/ procedure. Treatment may fail for unexplainable reason(s).

4- Tooth with previous root canal treatment that is failing (need to be retreated) will have a lower success rate than teeth having root canal for the first time.

5- I confirm that I have provided Dr. Agolli/Alkhalil with an accurate and updated report of my physical/mental health history. Disclosure of medical/dental information is essential for proper diagnosis, and to help prevent unnecessary complications during the treatment.

6- Complications with root canal therapy include, but are not limited to:

a. Continued infection or developing of an infection, requiring Endodontic surgery (Apicoectomy) or extraction often involved tooth/teeth.

b. Pain, requiring use of medication/so Side effects of medication may occur.

c. Fracture (breaking) of the root or crown of the tooth during or after treatment. If the tooth already has a crown, or abutment for a bridge (fix or removable), there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns/ bridges or veneers are subject to breakage during this treatment.

d. Tenderness of the tooth following treatment due to possible complication with root canal treatment, physical stress from chewing, grinding, or the speed with which the body tissue heals. The jaw may be stiff and sore from holding the mouth open; jaw muscle cramps and spasms; there may be restricted mouth opening for several days/ weeks.

e. If the associated nerve (inferior alveolar/Mental/or upper teeth nerve), is injured or bruised during anesthesia injection, then numbness and/or tingling sensation in the lip, tongue, chin, gum, cheek and teeth may occur which is usually transient and may persist for several weeks or months but on infrequent occasions may be permanent (this also could happen due to
trauma from surgery, overfilling or over instrumenting the canal, extrusion of Gutta-percha/sealer outside the root that has close proximity to a nerve).

f. Complications may arise or discovered include: Discoloration of the treated tooth, loss of supporting tooth structure which makes the tooth not restorable, cracked roots, sinus perforation, sinus stuffiness, nasal bleeding, root perforation, canals blocked by prior filling or by natural calcification, any of which may require surgery or extraction of the treated tooth.

g. I fully understand that root canal instruments may separate (break) inside the canal. If it cannot be retrieved, it may need to be sealed inside the root canal. An additional surgical procedure (apicoectomy) may be necessary.

h. I fully understand that to maintain the tooth/teeth involved, I need to continue good oral hygiene. The tooth need to be restored by my general dentist and it is my responsibility to arrange for an appointment to have it restored or leakage and failure of the root canal treatment will happen.

i. Recommendation of this treatment is based on dental history, x-rays, clinical findings and diagnostic tests taken by the doctor. My needs and wants have also been taken into consideration.

9- I give Dr. Alkhalil/Agolli the full authority to decide and to do what is best in my interest, and this includes (but not limited to): Contacting my primary care physician/or specialist for any reason. If any unexpected difficulties occur, I may be referred for an evaluation, treatment or continuation of treatment to any health care provider in a medical or dental office to do what is best in my interest.

10- I understand the common side effects from medications which include nausea and stomach upset, allergic reactions such as swelling or itching. I understand that prescription medications may cause drowsiness, lack of awareness, poor coordination or poor judgment. I will not work or operate any vehicle, automobile or hazardous device until fully recovered from the effects of the medications.

11- I further understand that in case of acute emergency and in the event that I cannot reach Dr. Agolli/Alkhalil or the office directly, I should proceed to the nearest emergency room for medical attention. I am to contact Dr.Agolli/Alkhalil or the office if I have any additional questions in regards to the Endodontic therapy, or if I experience any unexpected reactions.

My signature below signifies that all my questions have been answered to my satisfaction. I certify that I speak, read, write and understand English.

_____ _____
Signature and name of patient Date

_____ _____
Signature of parent/tutor and name of patient (if minor) Date

_____ _____
Witness Signature Date