Intercoastal Endo
Mark Conard D.M.D., M.S.

PATIENT CONSENT FORM

I _____ am giving the Doctor consent to examine my mouth and evaluate my need for any endodontic treatment that may be necessary.
I have been advised by the Doctor that I require a root canal/endodontic treatment for tooth/teeth number(s): _____. The Doctor has explained the method and manner of the proposed treatment, the desirability of root canal therapy versus extractions, and the possible consequences of having root canal therapy, including, but not limited to the following:

1. Postoperative discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor. Persons with chronic pain syndrome, whiplash, TMJ, fibromyalgia, etc. will have a longer period of healing due to central sensitization.
2. Postoperative swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
3. Infection.
4. Trismus (restricted jaw opening) This might last several days but may last longer.
5. Success rate 90%-95%. The treatment may have to be redone, root end surgery may be required, or the tooth may have to be extracted.
6. Breakage of root canal instruments during treatment, which may, in the judgment of the doctor, be left in the treated root canal or require surgery for removal.
7. Perforation by the root canal instruments, which may require additional surgical corrective treatment or result in premature tooth loss or extraction.
8. Premature tooth loss due to progressive periodontal (gum) disease in the surrounding area.

I understand that the long term prognosis following ROOT CANAL TREATMENT on tooth/teeth number(s)_____will increase if the tooth/teeth is protected against fracture by placement of a crown (cap) over the tooth/teeth. You, your dentist, and/or treatment may require the removal of a crown, bridge, or post from the area to be treated. Porcelain and bridge joints can be damaged during an attempt to remove or removal of the dental restoration. The porcelain and post system may also be damaged if you, your dentist, and/or treatment require we drill into the dental restoration.

I understand that if I have a problem after the Root Canal Treatment, I will call the office to have the tooth evaluated.
I understand if a staff member is injured while managing my care, in a manner that can possibly transmit a communicable disease, I will submit for testing for infectious diseases at a designated medical facility. (Example: needle stick injury)
No warranty or guarantee of success has been or can be given in Root Canal Treatment.

The doctor has answered all of my questions and I fully understand the above statements in this CONSENT FORM.

1. Can you read and understand English? **Yes_____** **No_____**
If No, do you have an interpreter? **Yes_____** **No_____**
2. Have you read this consent form? **Yes_____** **No_____**
3. Do you understand this consent form? **Yes_____** **No_____**
****** If your x-rays are needed for a teaching case, do we have your permission to use them? Yes____ No_____**

Treatment of _____ Estimate = $_____

Patient Portion Day of Treatment Estimate = $_____

****ESTIMATE ONLY, FEE SUBJECT TO CHANGE IF COMPLICATIONS OCCUR****

Date:_____ Witness:_____

_____ _____
Patient, Parent or Guardian Dr. Mark Conard

IMPORTANT ***PLEASE DO NOT SIGN UNTIL YOUR TREATMENT HAS BEEN EXPLAINED***

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