Lincoln Endodontics --- Tate Vanicek D.D.S.

CONSENT FOR ENDODONTIC THERAPY

Patient Name: _____ Tooth/Teeth #: _____

Please read and sign when you understand all points. Feel free to ask questions for further clarification.

1. **Consent**: I hereby give my consent for Dr. Tate Vanicek to perform endodontic therapy of the tooth or teeth listed. I understand that root canal therapy (RCT) is a procedure to retain a tooth which may otherwise require extraction
2. **Success Rate**: I understand that root canal therapy has a very high degree of clinical success (90-95% of the routine cases are successful). I also understand that RCT started in another office *may* have a lower success rate. I also understand that with any branch of medicine or dentistry, guarantee of successful treatment cannot be given or implied even when treatment is performed under optimal conditions using state of the art optics, materials, and instrumentation.
3. **Retreatment Success Rate**: I understand that an endodontic Retreatment is more complex and involves both a time and a monetary investment due to the possibility of multiple visits and procedure specific dental supplies needed to provide that appropriate care. Retreatment cases may also have a lower success rate (70-85%) even when the procedure is carried out under optimal conditions using state of the art optics, materials, and instrumentation. As in routine RCT, a guarantee of successful treatment cannot be given or implied.
4. **Additional Treatment**: I understand that if the affected tooth and surrounding tissues do not favorably respond to endodontic treatment, a surgical procedure (apicoectomy) or possible extraction may be required.
5. **Crown & Restoration**: I understand that to accomplish the root canal procedure it is necessary to alter the existing tooth structure and/or restoration (including crown). These alterations will require the placement of a new restoration or crown following root canal therapy. I understand that proper restoration of the tooth after root canal therapy is necessary and that a crown is generally recommended on posterior teeth following the procedure to protect the tooth from fracturing. The fee for endodontic treatment does not include these restorative procedures. I understand that it is my responsibility to have an appropriate restoration placed following the root canal procedure in a timely manner as recommended.
6. **Recall Visit**: I understand that a periodic recall examination of the tooth including radiographs may be recommended to evaluate the healing response and it is my responsibility to follow through with the recall visit. There will be no fee for a recall visit.
7. **Procedure**: I understand that treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthesia agents and the placement of a rubber dam. In rare instances, the administration of local anesthesia may result in transient or permanent numbness of the anesthetized area. Also, a number of radiographs will be necessary to accomplish the endodontic procedure. The number of radiographs required will vary with the complexity of the case.
8. **Complications**: Possible complication/challenges of treatment include, but are not limited to:
    a. Curved canals and/or roots
    b. Calcifications in the root canal or pulp chamber space
    c. Procedural difficulties such as the separation of instruments in the root canal space and perforation of the crown or root while identifying the canal space & fractures of existing porcelain/ceramic restorations
    d. Fracture of the crown or root
    e. Infection, swelling or bruising of the adjacent tissue
    f. Stiffness of the jaw or stretching of the mouth and lips
    g. Discomfort during or following treatment
    h. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.
9. **Consent or Discontinue**: I understand that I am free to withdraw my consent and discontinue treatment at any time however; complications such as bone destruction, infection, swelling, and/or discomfort, etc. may predictably occur if the endodontic therapy is not completed.
10. **Visits Needed**: The number of treatment visits required to complete the endodontic therapy varies with the complexity of each case. Routine cases are generally completed in one or two visits.
11. If at any time I have questions regarding the treatment I am receiving, I can expect a prompt and thorough response.

SIGNATURES:

_____ _____ Date _____

Signature of the patient or legal designate

_____ Date _____

Signature of witness