Consent to Endodontic Treatment

This is my consent to authorize Dr. Joshua Goldfein to perform endodontic therapy on tooth/teeth #(s)_____. I further give my consent to Dr. Goldfein to take x-rays, administer any medications, local anesthetics, drugs, services or procedures that he deems necessary or advisable as a corollary to the planned endodontic treatment.

I understand that endodontic therapy is a procedure to retain a tooth that may otherwise require extraction. Endodontic therapy results in the removal of the pulp tissue (nerves, blood vessels), or their remnants, from the inside of the tooth, then seals the space with a filling material. Endodontic therapy enjoys a high degree of success, but because it is a biologic procedure, success cannot be guaranteed or warranted. Occasionally, a tooth which has had endodontic treatment may require retreatment, periradicular surgery, or even extraction. During treatment, there is a possibility of instrument separation within the tooth, perforation of the tooth structure in gaining access to the canals, and fracturing of the tooth itself. Following treatment the tooth must be restored to function with a protective restoration, usually a crown. Some teeth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these include, but are not limited to, pain, swelling, loss of tooth, infection and spread of infection to other areas.

Complications of endodontic therapy and anesthesia include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, numbness of the lip, gum or tongue, which rarely is protracted, and even more rarely permanent.

The nature of endodontic therapy has been explained to me. I have had the opportunity to have my questions answered to my satisfaction by Dr. Goldfein concerning the nature of treatment.

_____ _____

Patient Signature (Guardian if patient is a minor) Date

_____

Patient Name (Please Print)

_____ _____

Witness Date