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Endodontic Consent and Information Form

Before we begin your treatment, we would like you to know about the possible risks which endodontic (root canal) therapy may pose and possible alternatives to endodontic treatment. This information is not intended to alarm you. It is a means by which we determine that you have read, understood and consented to the procedures involved in endodontic therapy. We have been advised not to begin treatment on anyone who has not read and signed this form.

General Risks of Dental Procedures: Include (but are not limited to) complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications may include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth; thrombophlebitis (inflammation to a vein); reaction to injections; change in occlusion (biting); muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth or restorations in teeth; injury to other tissues; referred pain to the ear, neck and/or head; nausea; vomiting; allergic reactions; itching; bruises; delayed healing; sinus complications; and further need for surgery. **Initials** _____

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be intensified by use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medication and drugs. **Initials** _____

Risks More Specific to Endodontic Therapy: The risks include the possibility of instruments separated within the root canals; perforations (extra openings) of the crown or the root of the tooth; damage to bridges, crowns, existing fillings, or porcelain veneers, loss of tooth structure in gaining access to the canals, and cracked teeth. During treatment, complications may be discovered which make endodontic treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, separated instruments, curved roots, periodontal (gum) disease, and split or fractures of the teeth. Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although the endodontic treatment preformed will be preformed in a manner which will minimize and avoid risks and has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or even extraction. **Initials** _____

Other Treatment Choices: These include no treatment, waiting for more definite symptoms to develop, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas. **Initials** _____

I have carefully read the above statements about endodontic therapy, my questions have been answered to my satisfaction, and I give my consent to the procedure. I realize that I can obtain a copy of this form upon request. I also understand that upon completion of my root canal therapy in this office I will need to return to my general dentist for a permanent restoration of the tooth within 45 days of root canal therapy (being that the final restoration is essential to the success of root canal treatment and the retention of the tooth). I realize that a check up x-ray should be taken in 6 months by my general dentist or by the treating endodontist.

Consent: I, the undersigned patient (parent or guardian of the minor patient), have carefully read the above statements about root canal therapy, my questions have been answered to my satisfaction, and I give my consent to the procedure.

Signature of Patient or Guardian **Date**

Signature of Witness **Date**

Consent form reviewed by: **Doctor or Assistant**