

DENTAL HISTORY

Date of your last visit to a dentist _____ Reason for your last visit or series of visits. _____

With respect to any previous dental treatment:

1. Have you had endodontic (root canal) treatment previously? _____
2. Have you had abnormal bleeding or are you taking blood thinners? (ie. coumadin) _____
3. Have you been sedated or used nitrous oxide for dental procedures? _____
4. Are any of your teeth sensitive to heat, cold or pressure? _____
5. Do you have trouble opening for dental procedures? _____
6. Do you have pain or clicking in the jaw joint around your ear or grind or clench your jaw? _____
7. Is there a history of TMJ (jaw joint) problems? _____
8. Are there any sores or growths in your mouth? _____
9. Do you have any other dental complaints or concerns we need to know? _____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

INFORMED CONSENT

The doctor has explained to me that there are certain inherent and potential risks in any dental treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive:

Swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, teeth, or other areas, which is transient but on rare occasions may be permanent; reactions to injections or drugs; changes in occlusion (biting); limited jaw opening or spasm; temporomandibular joint difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing, sinus perforations, treatment failure; complications resulting from the use of dental instruments (broken instruments – perforation of tooth, root, sinus);, medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

The patient understands that root canal treatment(s) is a procedure to try to retain a tooth which would otherwise require extraction. The clinical success of root canal treatment ranges from 80-95%. There are certain biologic criteria including, but not limited to fractures, biting habits, root shape, unusually large abscesses, resistant bacteria, etc., that are beyond what conventional root canal treatment can correct. In these cases retreatment, surgery, or extraction are among additional treatments that may be offered.

It is the patient's responsibility to return to a general dentist within 2 weeks unless otherwise stated after root canal treatment is completed to have a crown or permanent filling placed. Failure to have the tooth restored properly can lead to fracture, reinfection, endodontic failure or other complications, for which we cannot be held liable.

You will be thoroughly consulted prior to any rendered treatment. You will be able to ask questions related to your case, and you will be given all possible treatment options.

Please note that during your treatment we have made every effort to comply with all OSHA regulations and CDC Guidelines concerning the federal guidelines for a health care facility. If you wish to review our compliance manual, we will make it available to you.

Patient's Signature _____ Date/Time _____

Doctor's Signature _____ Date/Time _____

Witness' Signature _____ Date/Time _____