Dr. Ottosen & Nygard Endodontics **Dr. Stephen R. Ottosen, D.D.S, M.S.D**
Practice Limited to Endodontics **Dr. Kevin P. Nygard, D.D.S, M.S**

Record of Discussion and Informed Consent for Endodontic Treatment

1. _____ Root canal therapy is an attempt to save a tooth which otherwise may require removal. There are certain risks inherent in any treatment plan or procedure. I understand the risks include but are not limited to: complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. The complications include, but are not limited to: swelling, sensitivity, bleeding, pain, infection, cold sores, numbness and tingling sensation (paresthesia) in the lip, tongue, chin, gums, cheeks and teeth which are transient in most cases but on infrequent occasions may be permanent; reactions to injections, changes in occlusion (biting); jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth, crowns or bridges; referred pain to ear, neck and head; nausea, vomiting, allergic reactions, delayed healing, sinus perforations, discoloration of the face and treatment failure. Fractures of the tooth (teeth) or crown(s) may occur during or after treatment.
2. _____Specific to non-surgical root canal therapy, risks include, but are not limited to, the risks stated in paragraph one (l) above. However, additional risks are possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible and which may require dental surgery. These complications may include, but are not limited to, blocked canals due to filling or prior treatment, natural calcification, broken instruments, curved roots, periodontal (gum) disease and fractures of the teeth, or over-extrusion of root canal fi11ing material.
3. _____ I do understand that during and following treatment, I may have periods of discomfort. I further understand that many factors contribute to the success or failure of root canal therapy that cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed or may fail following treatment. Some of these factors include, but are not limited to, my resistance to infection, the shape and location of the canal anatomy, my failure to keep scheduled appointment(s), the failure of my having the tooth restored following the treatment, periodontal (gum) involvement, or an undetected or an "after-the- fact" caused fracture in the tooth. I further understand that during and following treatment, I am to contact Drs. Ottosen & Nygard Endodontics and/or staff if I have any additional questions, and/or if I experience any unexpected reactions. It will be my responsibility to contact my restorative dentist to see if any other treatment is indicated.
4. _____ I further understand that prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, which may be exaggerated by the use of alcohol, tranquilizers, sedatives or other drugs. It is not advisable to operate any vehicle or hazardous device until recovered from their effects. The use of antibiotic (penicillin, etc.) drugs may make birth control pills ineffective.
5. _____ I have been given the opportunity to ask questions and I have received answers in words I understand concerning the nature of the treatment, the inherent risks of the treatment, the alternative(s) to this treatment, if any, and it's/their risks. I understand that I will always have the option of no treatment or extraction as opposed to acceptance and/or continuance of the recommended treatment. I understand that root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed, and no guarantees have been made. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery or even extraction.
6. _____ I have followed all pre-operative instructions provided by Drs. Ottosen & Nygard Endodontics and/or staff and my medical and other dental care providers. I have completed a MEDICAL HISTORY FORM on this visit or on a past visit. There have been no changes except those noted on my latest MEDICAL HISTORY CHANGE FORM.

I authorize the doctors of Drs. Ottosen & Nygard Endodontics and any other agents or employees of Drs. Ottosen & Nygard Endodontics and such assistants as may be selected by any of them, to treat the following conditions: Root canal, re-treatment, apicoectomy (surgery), root amputation, extractions, other:_____

My options for treatment are: ___Root Canal ___Re-Treatment ___ Apicoectomy(surgery) ___Root Amputation ___Extraction ___Other:_____

The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s)
X _____
____

The Prognosis for this(these) procedure(s) was described as: ___Good ___ Fair ___Questionable ___Poor

If there is anything that you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form and talking to the doctor, please write your questions below. If you have no questions, please write "**NONE.**"

_____
_____

Patient signature: X_____ **Patient name:** _____
If under 18 years old, circle: parent/legal guardian; relationship to patient: _____
Doctor signature: X_____ **Assistant Signature: X**_____
Date: _____ **Time:** _____am/pm