Legacy Endodontics
Wade R. Hirschman, DDS, MS

Record of Discussion and Informed Consent for Surgical Endodontic Treatment

Please read the following information. Do not write on the form until directed to do so by the doctor. Your complete understanding of the benefits, risks and outcome of your treatment is important to us. We will be pleased to answer any questions you may have.

_____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 is transient in most cases but on infrequent occasions may be permanent; reactions to injections, changes in occlusion (biting); jaw muscle cramps and spasms, tempromandibular (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 surgical root canal therapy, risks include, but are not limited to, the risks stated in paragraph one (1) above. However, additional risks of anesthetics may be increased due to the amount of agents used and the duration of the procedure. Damage to adjacent teeth may require root canal treatment and/or extraction. Changes in the gum height in the surgical site causing exposure of crown margins which then may need to be remade for aesthetic reasons.

_____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 Dr. Hirschman's office 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 as indicated. I understand that I must schedule an additional check-up appointment within six-months.

_____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, and the alternative to this treatment. 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. 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 Dr. Hirschman's office and my medical and other dental care providers.

_____7. 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 Dr Wade R. Hirschman and any other agents or employees of Legacy Endodontics and such assistants as may be selected by any of them, to treat the following condition(s):

Pulpal:○Symptomatic Irreversible Pulpitis ○Asymptomatic Irreversible Pulpitis ○Pulpal Necrosis ○ Previous RCT ○Previously Initiated Therapy
Apical: ○Normal ○Symptomatic Apical Periodontitis ○Asymptomatic Apical Periodontitis ○Acute Apical Abscess
○Chronic Periradicular Abscess ○Condensing Osteitis
Other: _____

My options for treatment are: _____

The prognosis for this (these) procedure (s) was described as: Favorable/Guarded/Unfavorable
Notes:_____

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**."
_____
_____

By signing below I hereby acknowledge reading and understanding points 1 through 6.

Patient signature: X_____ Patient Name: _____
If under 18 years old, circle: parent/legal guardian; relationship to patient: _____
Doctor signature_____ Assistant signature_____
Date _____Time _____ am / pm