DENTISTRY Revolution
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Consent for Endodontic Therapy

Patient:_____ Date:_____

I give Dr. K. Kordsmeier permission to perform endodontic therapy for tooth #_____. I have been informed of the diagnosis (_____), the risks (chronic infection, fracture, perforation & others) & benefits (complete healing of dental infection with no discomfort, retained tooth in mouth & others) of the procedure & the alternatives (extract & leave space, extract & place implant supported restoration, extract and place a bridge, extract & place a partial denture) to this procedure. I understand that additional procedures may be necessary to resolve the infection that is in this tooth & that I may be asked to see a specialist for these procedures if necessary. I further understand that failure of this procedure is a possibility. This may necessitate that the tooth be extracted ("pulled") at a later date. In many cases failure occurs because the tooth is not properly restored after the endodontic therapy. This may result in further contamination of bacteria back into the root canal space. I have been informed that files (Nickle Titanium rotary files & hand files) will be used to prepare the canals & that it is possible that a portion of this file can become separated off inside the canal making it difficult to properly clean & fill this canal. This may not cause any long term discomfort for the patient or the need for extraction, but it is a possibility.

The doctor and staff have informed me of the procedure and I have been given sufficient time to ask any questions that I may have.

Patient: _____ Date: _____

Witness: _____Date: _____