Aspen Springs Dental
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Endodontic Consent Form

I hereby consent to endodontic treatment procedure for myself (or my minor child), ____, on tooth number _______, to be performed by Dr. Landon Blatter or Dr. Shaun E. Soucie. I understand that the tooth is infected or that the nerve has been exposed. The reason for treatment is to remove the infected or exposed nerve to prevent re-infection. The alternative treatment of removal of the tooth has been explained to me, as well as possible results if no treatment is performed. I also understand the possible consequences of not completing endodontic treatment once it is initiated.

I understand that during or after endodontic treatment there is a possibility that the following may occur: Pain, swelling, infection, re-infection, cold sore, canker sores, irritation or injury to the oral mucosa, periodontal involvement (loss of bone and tooth mobility due to infection), breakage of instruments (such as files), within the root canal or tooth, calcified canal preventing endodontic therapy through the entire length of the root, perforation of the crown or root of the tooth by the dental instruments or as a pre-existing condition, allergic reactions to dental materials or medications.

I understand that root canal therapy is not 100% successful (80-90%) and that the endodontic procedure may have to be repeated and/or additional minor surgical procedure may be required. Sometimes multiple appointments are necessary to complete a single root canal.

I understand that after endodontic treatment, the tooth will require restorative treatment. Although root canal treatment can save the tooth, the procedure may weaken the tooth and causes the tooth to become brittle, turn darker in color and more susceptible to fracture. Therefore a crown restoration may be indicated upon completion of endodontic treatment.

I hereby certify that I fully understand this authorization for endodontic treatment. I have been given the opportunity to ask questions and have been given satisfactory answers. I am aware that the practice of Dentistry and Endodontics is not exact science and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above.

Patient or authorized person signature ______________________________________
Date __________________

Witness Signature ____
Date __________________

Doctor's Signature ____
Date __________________