Great Neck Endodontics
Peter Rybak DDS
15 Canterbury Road, Suite A2
Great Neck, NY 11021
tel. (516) 441-5060 fax (516) 570-2509
info@greatneckendo.com
www.greatneckendo.com

Informed Consent for Root Canal Treatment

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endondontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by root canal therapy or periapical (root end) surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment options.

Risks: The risks include: the possibility of instruments separating within the canals, perforations (extra openings) of the crown or root of the tooth, damage to bridgework, damage to existing fillings, crowns, or veneers, loss of tooth structure in gaining access to canals, and cracked or fractured teeth. During the treatment complications may include: blocked canals due to fillings or prior treatment, natural calcifications (narrowing of canals), separated instrument within canals, curved roots, periodontal disease (gum disease), or splits or fractures of teeth. There is also the possibility op post operative pain, swelling, sensitivity, or paresthesia (sensation of tingling, burning, pricking, or numbness).

Other Treatment Options: These include no treatment (waiting for more definite development of symptoms) or tooth extraction. Risks involved with these choices include pain, infection, swelling, loss of teeth, and infection locally, and to other areas.

Consent: I, ______________________ , being the patient or parent / guardian of a minor below 18 years of age, consent to the performing of procedures decided upon to be necessary and advisable in the opinion of the doctor. I also understand that upon completion of the root canal, I shall return to my general dentist for the permanent restoration of the tooth involved, which may include crowns, caps, onlays, and white or silver fillings.

I understand that root canal treatment is an attempt to save a tooth, which may otherwise need extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment of the root canal, root surgery, or even extraction, at additional cost to me.

I hearby authorize Dr. Peter Rybak, at Great Neck Endodontics, at 15 Canterbury Road, Suite A2, Great Neck, NY 11021, to perform upon me or the named patient the following procedure:

Root canal therapy of tooth # ______.

Root Canal Retreatment of tooth # ______.

Signature of Responsible Party __________________________ Date ______________

Printed name of minor is applicable __________________________

Doctor's Signature __________________________ Date ______________