Consent to Endodontic Treatment

The Florida Medical Consent Law requires doctors to advise patients of the general nature of treatment or procedures, the medically acceptable alternative procedures or treatments, and the substantial risks inherent in the proposed treatment or procedures. In signing this consent form, you are agreeing that you have been advised of these matters to your satisfaction and understand that one alternative is not to have any treatment at all with full understanding of the risks and hazards of declining treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by the endodontists Dr. Lauren H. or Dr. Glen B. Mitchell, associate Doctors, and any assistants with whom they work. I agree to the use of local anesthesia, depending upon the judgement of the endodontist. I understand the endodontist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. Complications of root canal treatment and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, bruising, sinus involvement, allergic reactions, delayed healing, treatment failure and numbness or tingling sensations of the lip, gum, cheek or tongue, which is transient but on infrequent occasions may be permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling, crown and/or post and core) will be necessary to restore the tooth to function within one month; this will be performed by another dentist for an additional expense. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

Patient Signature _____ Date _____

Doctor _____ Witness _____

(PLEASE CIRCLE) Dr. Mr. Mrs. Ms.

First Name _____

Last Name _____

Birth Date _____

Social Security # _____

Home Address _____

_____

_____

Home Phone _____

Business Phone _____

Cell Phone _____

Referred By _____

Employer _____

Occupation _____

Insured Person/Subscriber

Name _____

Birth Date _____

Social Security #

_____

Employer _____

Spouse Name

_____

Birth Date _____

Social Security #

_____

Employer _____

Business Address _____

Do you have or have you had any of the following?

Mitral Valve Prolapse (MVP)	YES	NO	Glaucoma	YES	NO
Heart Murmur	YES	NO	Venereal Disease	YES	NO
Rheumatic Fever	YES	NO	Kidney Disease	YES	NO
Angina	YES	NO	Ulcers	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO
High Blood Pressure	YES	NO	Radiation Therapy	YES	NO
Low Blood Pressure	YES	NO	Chemotherapy	YES	NO
Anemia	YES	NO	AIDS	YES	NO
Bleeding Problems	YES	NO	Psychological Diagnoses	YES	NO
Liver Disease	YES	NO	Neurological Disorders	YES	NO
Thyroid Disease	YES	NO	Trauma	YES	NO
Asthma	YES	NO	Substance Abuse	YES	NO
Lung Disease	YES	NO	Stroke	YES	NO
T.B.	YES	NO	Seizures	YES	NO
HIV	YES	NO	Surgeries	YES	NO
Hepatitis	YES	NO	Heart Problems	YES	NO
Diabetes	YES	NO	Cardiovascular Disease	YES	NO

1. Are you in good health? YES NO

2. Are you presently under the care of a physician? YES NO

If so, what for _____

_____

3. Are you presently taking any drug or medications? YES NO

What Medication	For What Condition

4. Have you had heart/cardiac surgery or vascular surgery? YES NO

5. Do you have damaged or artificial heart valves? YES NO

6. Artificial Joint or Prosthetic Device? If so, when was it placed _____ YES NO

7. Do you have a cardiac pacemaker/Shunts? YES NO

8. Do you experience chest pain upon exertion? YES NO

9. Do you routinely take aspirin on a daily basis? YES NO

Pregnant? YES NO Nursing? YES NO Birth Control Pills? YES NO

Missed period or possibility of pregnancy? YES NO

Please circle any of the following drugs to which you may be allergic:

Penicillin	Ibuprofen (Motrin, Advil)	Codeine	Novocaine/Local Anesthetic
Erythromycin	Aspirin	Latex	Other Allergies?
Other Antibiotic	Local Anesthetic	Adrenaline	_____

Do you have any diseases, syndromes, symptoms or other medical problems not mentioned above? YES NO

If so please explain _____

Name and Address of Physician _____

_____

Signature _____ Date _____