Vaughn Endodontics

CONSENT FOR ENDODONTIC THERAPY (Root Canal Treatment)

Endodontic therapy involves the removal of a portion of the inside of the tooth and is intended to save the tooth. This office specializes in endodontic therapy. Although endodontic therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had endodontic therapy may require re-treatment, surgery or even extraction. Following treatment, the tooth may be weakened and subject to fracture. Therefore, a permanent filling will be necessary. A crown with permanent filling may be necessary to permanently restore the tooth. Your general dentist will provide the permanent filling and crown as necessary. Although the exception, during endodontic treatment there is the possibility of instrument separation (breakage) within the root canals as well as a possibility of perforations, damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals and fractured teeth. There are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment.

*Other treatment options in treating tooth infection include tooth extraction (pulling the tooth) or a waiting period for more definitive symptoms to develop.

*Risks involved in delaying treatment might include, but are not limited to: pain, infection, loss of teeth and infection to others areas.

*All medical records will be kept strictly confidential.

*I fully understand the above statements in this consent form.

Patient/Guardian Signature _____ Date _____

INFORMED CONSENT FOR CBCT (Cone Beam Computerized Tomography)

A CBCT scan produces images of your tooth that depict internal structures in cross section (3D Image), rather than the overlapping images typically produced by conventional X-ray exams. CBCT scans are useful in looking at conditions which may be missed on a conventional X-ray. The CBCT scan may enhance your dentist's ability to see what he/she needs to see before or during treatment.

WOMEN: CBCT scans are NOT recommended for pregnant women because of danger to the fetus.
Initial appropriately: ___ I am Not pregnant ___I am pregnant ___I am unsure whether I am pregnant.

Risks: CBCT Scans, like conventional X-rays, expose you to radiation. An alternative to a CBCT scan are conventional dental X-rays, however, they have the limitations previously noted.

While parts of your anatomy beyond your mouth and jaw may be seen on the scan, your dentist is not a physician or specialist regarding assessments concerning your anatomy beyond your mouth or jaw. If the report raises a question as to something unusual outside the specific area of the mouth or jaw, you dentist may refer you to a physician for an evaluation. In such an event, our office can place the image on a CD. You should also understand that CBCT images do not show most soft tissues or fluids, so some problem areas may have to be imaged with other methods.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS

I, _____, being 18 years or older, certify that I have read this consent form in the presence of _____, and that I understand the procedure to be performed and its benefits, risks and alternatives. I give my informed consent to Dr. _____ and their designated staff to perform the CBCT scan. I also acknowledge that Dr. _____ sole responsibility is to interpret the scan regarding the tooth in question; in order to determine further dental treatment. I acknowledge the interpretation will be communicated directly to me and my referring /treating dentist by designated staff.

I acknowledge that the designated staff will provide information based on the doctor's interpretation. Any additional interpretation or counseling concerning the results of the scan will occur between the doctor and patient.

Signature of Patient or Legal Guardian _____ Print Name _____

Date _____