Apopka Endodontics

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CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. ***Your signature does not commit you to any treatment.***

Occasionally, medication will be prescribed by Dr. Ferguson. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call Dr. Ferguson immediately. It is the patient's responsibility to report any changes in his/her medical history to Dr. Ferguson.

I understand the root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this 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, and your general dentist will perform these procedures. During endodontic 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 the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period 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.

I fully understand the above statements in this consent form. Furthermore, I give Dr. Ericka Ferguson my permission to voice record, tape digitally, videotape and/or take 35mm and/or digital photos of my procedure for purposes of completing my medical record and/or for patient education.

Note: All medical records will be kept strictly confidential.
(If patient is under the age of 18, the signature of a parent or guardian is required.)

☐ *I have read and understand all of the above*

Signature: _____ Date: _____