



SMYRNA DENT

ENDODONTIC TREATMENT (ROOT CANAL THERAPY) INFORMED CONSENT FORM

The objective of this form is to enable your participation into the decision making process about your healthcare by informing you.

This form has been designed in order to meet the needs of many patients under most conditions, nevertheless, it should not be considered as a document containing the risk of the entire applicable treatment. Based upon your individual healthcare, your physician may provide you with different or additional information.

After acquiring the advantages and possible risks of diagnosis, medical treatment and surgical interventions, it is up to your decision whether or not to accept these procedures. You are entitled to refuse to be informed except for the legal and medical necessities or withdraw your consent at any time.

Information About the Disorder

Pulp is the living part of the tooth. It includes nerves and thin blood vessels. Dental pulp may be infected for various reasons due to deep bruises, traumatic injuries, previous root canal treatments, large preparations in the tooth. In such cases, the infection may develop immediately or takes some time to be observed. Infected pulp tissue can be painful or indolent. Sometimes it is possible to see the infection on dental radiography and sometimes not. Dental pulp has no chance of healing this infection.

We try to treat the infected teeth first. Because the current infection can be controlled by root canal treatment. With this routine procedures, the teeth can be saved and patients can continue to use their own teeth for many years. Duration in the mouth for the infected teeth that have been successfully treated is comparatively long.

Completion of the endodontic treatment can take several appointments. It may take a few months for this recovery to be completed and for the tooth to become aseptic and for the pain to disappear completely. Its changes in radiographic images can also be seen after a few months. During this period, it may be necessary to have radiography many times. In our clinic, radiographs are taken with a special phosphate plate method which reduces the transmitted beam by 80%.

After the endodontic treatment is completed, the tooth should usually be restored with crown or onlay. Breakages are more common in teeth that were undergone root canal treatment and/or in infected ones. The tooth breaks may occur even during the treatment to remove these infections/lesions in your teeth.

You may have uncomfortable days between the appointments during an infected root canal treatment. This is a very normal pain and there is usually nothing to worry about. You may not have any pain in your teeth until you have root canal treatment, and you may not be aware of the existing abscess. However, you may experience swelling and pain after the root canal treatment has been started. During and after the root canal treatment, be careful not to bite on it until the upper restoration is completed.

If antibiotics are prescribed in addition to your treatment, be sure to take it regularly and until it is finished. This is important to rapidly control the infection. If you cannot take the prescribed medication or use it regularly, the healing of the abscess may take time and the risk of pain after treatment is more likely to develop. If you have a very severe pain or swelling in your face, you can contact our clinic on 24 hours a day.

Please contact us if you have any problems with root canal treatment and upper restoration.

Risks Related to Procedure

These are swelling in the face, severe pain and loss of teeth.



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Diagnosis _____

Treatment/procedure to be applied _____

Side/grade if applicable Right sided Left sided Both sided Grade _____

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do not accept the treatment, please declare so below with your hand writing.

I hereby declare that;

My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that it does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I will experience on the condition that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered all my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healthcare professionals under the authority, surveillance and control of my attending physician.

I have been informed that if required, anesthesia will be performed by an anesthetist, sedation will be performed by an anesthetist or another physician competent in sedation and local anesthesia will be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team will carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs removed during the procedure for which I have consented above.

I allow my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

Patient's			
Full Name:	Signature:	Date:	Time:
Date of Birth:			
Legal Representative's			
Full Name:	Signature:	Date:	Time:
Degree of Relationship:			
Reason why the consent is delivered by legal representative of the patient:			
<input type="checkbox"/> Patient is not conscious	<input type="checkbox"/> Patient is under 18		
<input type="checkbox"/> Patient is not entitled to make decision	<input type="checkbox"/> Emergency		
Witness'			
Full Name:	Signature:	Date:	Time:
Informing Physician's			
Full Name:	Signature:	Date:	Time:
Interpreter's (If required)			
Full Name:	Signature:	Date:	Time:

Informed consent is delivered by the patient himself/herself if s/he is older than 18 years old, by the patient himself/herself together with his/her legal representative if the patient is aged between 15 and 18 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case of emergency.