

INFORMATIONAL INFORMED CONSENT

SEALANTS

I UNDERSTAND that the treatment of teeth through the use of sealants is a preventive measure intended to facilitate the inhibition of dental caries (tooth decay) in the pits and fissures of the chewing surfaces of the teeth. Sealants are placed with the intent to prevent or delay conventional restorative measures used in restoring teeth with fillings or crowns after the onset of dental caries. I agree to assume any risks if any, which may be associated with the placement of sealants even though care and diligence will be exercised by

Dr. _____ in rendering this treatment. Those risks include possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. **Preparation:** The teeth are prepared through use of an enamel etching technique. This etching is accomplished in one of two ways:
 - a. Through using a special acid solution which merely etches the surface enamel in the area in which the sealant is to be placed to aid in its retention. The etching solution is somewhat caustic and if the patient makes any quick movements or interferes with the application of the etching agent there is a remote possibility of a small amount of the solution finding its way onto small areas of the soft tissues of the mouth which could cause some slight tissue burns. This seldom occurs, but there is a remote possibility. If the etching solution contacts the root surface the tooth may develop transient sensitivity.
 - b. Through using a technique called air abrasion. Air abrasion also slightly etches the surface of the enamel in the area in which the sealant is to be placed to aid in the retention of the sealant. Air abrasion involves the generation of a powdery dust which is sometimes accidentally inhaled and could cause some discomfort.
2. **Loosening and/or dislodging:** There is the possibility of the sealant loosening or becoming dislodged over a period of time. This time is indeterminable because of many variables including, but not limited to the following:
 - a. The forces of mastication (chewing). These forces differ from patient to patient. The forces may be much greater in one patient than in another. Also, the way the teeth occlude (come together in chewing) may have an effect on the life of the sealants.
 - b. The types of food or other substances that are put in the mouth and chewed. Very sticky foods such as some types of gum; sticky candies such as caramels; some licorices; very hard substances, etc; may cause loosening or dislodgment.
 - c. Inadequate oral hygiene such as infrequent or improper brushing of the teeth also may allow leakage around and under the sealant causing it to loosen and allow decay to develop.
3. **Entire tooth is not protected with sealants:** Sealants are applied primarily to the pits and fissures that are in the chewing surfaces of the teeth. These pits and fissures are extremely susceptible to decay and can be protected through the application of sealants which flow into and seal those areas. However, sealants do not protect the areas between the teeth, so thorough brushing and the use of dental floss in these areas is necessary. Otherwise decay could develop in those areas uncovered by the sealants.
4. **I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing assessment of the sealants placed.**

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of sealants and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of achieving the desired results from the treatment rendered. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Dr. _____ and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

Patient's name (please print)

Signature of legal representative

Date

Witness to Signature

INFORMATIONAL USE ONLY

ROOT CANAL RETREATMENT

I UNDERSTAND THAT ROOT CANAL RETREATMENT includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of successful results have been made.

1. **A tooth which has had root canal treatment previously** may possibly become excessively tender or painful at some time following the initial root canal treatment for various reasons. Should this occur the tooth may require additional procedures, including retreatment, apical surgery, or extraction.
2. Should anesthesia be necessary there is a possibility of numbness occurring in the tongue, lips, teeth, jaws and/or facial tissues resulting from either the anesthetic administration or treatment procedures. Numbness is usually temporary but may be permanent.
3. **Extensive complicated treatment may be necessary.** When retreatment is necessary, the removal of the previous root canal filling material may involve difficulties such as pulp chamber or root perforation, root fracture, or other complications. This may possibly necessitate referral to a specialist or may even require extraction of the tooth.
4. **Instrument separation may occur.** Because of the small diameter and fragility of root canal instruments, there is a possibility of an instrument separating. Many times the separated part of the instrument can be removed or even retained without causing problems. No matter how carefully instruments are manipulated the possibility of separation exists.
5. **A previously root canal treated tooth may subsequently become infected.** Should this occur, it may be difficult to control the infection with retreatment only of the root canal and/or administration of antibiotics. The tooth may require a procedure called an apicoectomy that entails surgical removal of the end of the root and placement of filling material. In most instances, this treatment will take care of the problem. However, at times this procedure may not produce the desired result and preservation of the tooth.
6. **A retreated tooth may become brittle.** Because of the loss of vital tissue in the pulp chamber and root canal, a tooth may become excessively brittle and break (fracture). At times, this could occur subsequent to retreatment. In such cases, the tooth may be preserved with a crown buildup and a crown to restore the tooth unless the fracture is too severe or too extensive. Should the fracture be too extensive for a crown buildup or extend below the level of supporting bone, the tooth may need extraction.
7. **Should extraction be required,** replacement could be made with some type of prosthesis such as a fixed bridge, a removable bridge, or an implant.
8. **Alternatives to root canal retreatment.** Should it be determined to not retreat a tooth previously treated with a root canal procedure, alternatives such as extraction followed by fixed or removable bridgework, or implants may be considered.
9. **Medications.** Should infection and/or pain be present, it may be necessary to prescribe medication. Drugs prescribed must be taken strictly according to instructions. Patients on oral contraception must be aware that antibiotics may render these contraceptives ineffective. Other methods of contraception should be utilized during the treatment period if antibiotics are used.
10. **TREATMENT MUST BE COMPLETED.** It is absolutely necessary to complete the root canal retreatment procedure once it is begun, otherwise serious problems may develop. It is the patient's responsibility to schedule and keep the necessary appointments and also to notify this office should unanticipated problems occur concerning the treatment. Also, the patient must diligently follow all preoperative and postoperative instructions and keep all scheduled appointments.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of root canal retreatment and have received answers to my satisfaction. I have been given the option of seeking this treatment from a specialist. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. _____ and/or his/her associates or agents to render any treatment necessary and/or advisable to my dental condition(s), including prescribing and administering any and all anesthetics and/or medications.

Patient's Name (please print)

Signature of patient, legal guardian, or
authorized representative

Date

Tooth No.(s) _____

Witness signature

Date