WEST HAVEN
DENTAL CARE LLC
Anthony D. Bellucci, D.M.D.

CONSENT FOR ROOT CANAL THERAPY

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained the procedure to me and the anticipated results of the root canal therapy. I understand that this is an elective procedure and that there are alternative treatments and the doctor has explained the risks and benefits of the alternatives. I also understand that root canal therapy has an excellent success rate, but the doctor has not guaranteed or warranted a perfect result.

The doctor has explained to me that there are certain potential risks in the procedure. These include:

- Inability to completely fill the root canal because the canal is calcified or has a unique curvature. This may require endodontic surgery or extraction of the tooth.
- Infection that may occur and may continue, requiring further endodontic surgery, extraction, or antibiotic medication.
- Fracture or breakage of the root or crown portion during or after treatment.
- Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved.
- Perforation of the tooth during treatment.
- Damage to existing fillings, crowns, or porcelain veneers.

Unforeseen conditions may arise that require a procedure that is different than set forth above and require a referral to a specialist. I authorize the doctor to perform such procedures when in their professional judgment the procedures are necessary.

I understand that the medications, drugs, anesthetic and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

Please do not hesitate to ask the doctor or staff if you have any questions.

Patient, Parent/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____