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DISCUSSION & INFORMED CONSENT FOR PULPOTOMY OR PULPECTOMY OF PERMANENT TOOTH
Rev 03/2018

A pulpotomy is an interim treatment done with the intention of temporarily preserving a vital tooth without removing all of the pulpal or nerve tissue. During a pulpotomy, tissue is generally removed from the pulp chamber but tissue contained in the root canals of the tooth remains. Complete removal of tissue from within the tooth is called a "pulpectomy."

I understand that a pulpotomy or pulpectomy are performed as a temporary measure in all but the most unusual cases. This treatment is an attempt to preserve the tooth for an undetermined period of time, and it may involve inherent risks including but not limited to the following:

1. **ROOT CANAL TREATMENT:** Even though it is anticipated that this treatment may extend the time in which a tooth will remain vital until further necessary procedures may be successfully performed at a more appropriate time, it may be necessary to perform complete root canal treatment (pulpectomy) if conditions should so dictate. Care should be taken not to unduly delay completion of the root canal process. Referral to an endodontic specialist may be necessary as determined by the attending dentist.
2. **NUMBNESS:** I understand that I may receive a topical and/or local anesthetic by injection and/or other medication(s). I understand that I may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections. In rare instances, patients can have a strong and unpredictable reaction to the anesthetic, which may require emergency medical attention. The medication may affect my ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. *Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury resulting in loss of feeling of the chin, lips, gums, tongue and partial loss of taste can result from an injection.*
3. **MEDICATION(S) RISK:** I understand that all medications in this office have the potential for accompanying risks, side effects and drug interactions. They can cause redness and swelling of the tissues, pain, itching, vomiting and/or anaphylactic shock. I attest that to my knowledge, I have given an accurate report of my physical and mental health history. I have also report any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
4. **TRISMUS:** I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most

significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

5. **FRACTURE:** The crown portion of the tooth may have been weakened because of the nature of the procedure and/or the tooth injury or disease that necessitated this procedure, the tooth may be more susceptible to fracture or breakage.
6. **TEMPORARY CROWN:** Should the remaining tooth structure appear to be excessively fragile, it may be necessary to place a temporary crown on the tooth in order to preserve it.
7. **EXTRACTION:** If the tooth does not heal, if it fractures extensively or if it is unacceptable for the performance of a complete root canal treatment, extraction of the tooth may be necessary.
8. **PAIN:** In most cases, once the pulpectomy has been performed and the initial pain has subsided, the tooth is no longer painful. However, in some cases, severe pain or extreme sensitivity will persist. If so, it is the patient's responsibility to notify the dentist immediately.

I acknowledge that it is my responsibility to seek immediate attention should any undue problems occur after treatment. I shall diligently follow all preoperative and postoperative instructions given to me.

FOR ALL PATIENTS

I understand that every reasonable effort will be made to ensure the success of my treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The dentist will explain all changes.

I have been given the opportunity to ask questions about Pulpotomy or Pulpectomy of Permanent Tooth and believe that I have sufficient information to give my consent as noted below.

CONSENT

I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition. I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have treatment performed. While the treatment may be covered by my medical and/or dental insurance, I accept any financial

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responsibility for this treatment and authorize treatment.

If I am signing for a minor child, I attest that I am the parent and/or a legal guardian or I have the permission of the child's parent and/or a legal guardian (a separate authorization form is required). If I am signing for an adult, I attest that I am a legal guardian and am authorized to make medical and financial decision on patient's behalf.

16160 Monterey Road, Morgan Hill, CA 95037
☎ (408) 782-6568 🖷 (888) 503-6560
✉ info@stDental.com www.stDental.com