CONSENT FOR ROOT CANAL TREATMENT (ENDODONTICS)

I have the right to be informed about my diagnosis and planned treatment so that I can make a decision to undergo treatment after knowing the expectations and risks involved.

This Consent for Root Canal Treatment is given to Dr. _____ ("the Dentist") after first having been provided with a full explanation of my diagnosis, the proposed treatment, the alternatives, benefits, and risks of the proposed treatment, and the opportunity to ask questions.

DIAGNOSIS

The Dentist has explained that I have been diagnosed with _____

_____

PLANNED TREATMENT

The Dentist has recommended that I have root canal treatment. Root canal treatment, or endodontics, involves the treatment of the tissue inside of the tooth. Endodontic treatment is necessary if the pulp, the soft tissue inside the tooth and its root or roots (the root canal), becomes inflamed or infected. The Dentist will make an opening at the crown of the tooth and remove the diseased pulp. The Dentist will clean, shape, and fill the root canal. The Dentist may place a temporary filling in the crown. If I receive a temporary filling, I will need to return to the Dentist to have a crown and/or other restoration placed to protect and restore the tooth to its full function. I understand that if I fail to get a custom and permanent crown within reasonable amount of time (typically within 7 days) after my root canal, my tooth could break and become non-restorable.

ALTERNATIVES

An alternative to root canal treatment is extraction of my tooth. If the tooth is extracted and not replaced, the empty space may create problems in tooth alignment because of shifting of adjacent teeth or opposing teeth. This may result in periodontal (gum) disease and I could lose more teeth as a consequence. The missing tooth may be replaced by a fixed bridge, implant, or partial denture, and this may involve dental work on adjacent teeth.

If I choose not to have any treatment, I may have continued or increased pain, swelling, loss of the tooth, loss of adjacent or opposing teeth, abscess in the tissue and/or bone, and spreading of infection.

BENEFITS

Endodontic treatment may help me keep my tooth for a longer time.

Endodontic treatment may help to maintain my natural bite and healthy functioning of my jaws.

RISKS

Some complications of root canal treatment include, but are not limited to:

- A possibility of perforations of the tooth or root
- Damage to existing restorations (fillings)
- A possibility of a split or fractured tooth
- A possibility of pain, swelling, infection, or severe bruising of the face
- A possibility that an instrument may break off during the root canal that cannot be removed from within the tooth
- The use of prescription drugs during treatment may result in unexpected drug reactions
- Discomfort, swelling, and/or restricted jaw opening, which may persist for several days or longer following treatment

The occurrence of any of the complications described above may result in failure of the procedure and a need for possible re-treatment or extraction of the tooth.

This procedure may not remove all of the infected or inflamed pulp and my symptoms may continue or worsen and require additional treatment.

Sometimes it is not possible to access all canals in a tooth or completely fill them. This may affect the success of the procedure.

Some people who undergo root canal treatment may need additional treatment. This procedure may not remove all of the infected or inflamed pulp and symptoms may continue or worsen and require additional treatment.

During treatment, the filling material may extrude out of the root canal and into the surrounding bone and tissue, which may require additional treatment, such as an apicoectomy.

Successful completion of the root canal treatment does not prevent future decay or fracture.

There is no guarantee of a successful outcome.

CONSENT

By signing this consent form, I acknowledge that I have read and understand this Consent for Root Canal Treatment, and that I have asked and had answered all of my questions, if any, in a satisfactory manner.

I have read and understand the risks and complications with the root canal treatment.

I understand that the potential risks are not limited to those described above.

I understand that there is no guarantee of a successful outcome.

I understand that this is an elective procedure, and that I have a choice of other forms of treatment or no treatment at all.

I authorize the Dentist to perform endodontic treatment, as described above:

_____ _____

Print Name Date

_____

Signature

If this Consent is signed by a personal representative on behalf of the patient (for example, a parent or guardian), his/her relationship to the patient and authority to act on behalf of the patient must be set forth here:

Relationship to Patient: _____

Basis of authority to act: _____