

ROOT CANAL THERAPY CONSENT FORM

(# _____)

I have been made aware of my condition requiring endodontic (root canal) therapy in the opinion of my dentists. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequences of doing nothing will lead to worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease and infection problems.

Some complications of root canal therapy may be, but are not limited to:

- Failure of the procedure necessitating re-treatment, root surgery, or extraction
- Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer
- Breakage of an instrument inside the canal during treatment, which may be left as is, or may require surgery for removal
- Perforation of the canal with instruments, which may require additional surgical treatment or result in the loss of the tooth

I understand that it may take more than one visit to complete the root canal.

Successful completion of the root canal procedure does not prevent future decay or fracture. An endodontically treated tooth will become weak, brittle, and dis-colored. It can also become fractured into the root and can no longer be saved. **In order to maintain functionality and integrity, a crown (and possibly a post) should be placed on the root canaled tooth as soon as possible.**

By providing my signature, I certify that I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. I have had a chance to have all of my questions answered.

Signature of Patient or Legal Guardian: _____

Print Name Patient _____

Date: _____