Informed Consent: Root Canal Therapy

I, _____, authorize Dr. _____ and his/her dental assistant(s), staff to perform endodontic therapy and/or the necessary immediate alternative therapy for teeth #_____.

I authorize the use and administration of local anesthetics, the taking of x-rays, and immediate treatments that may be deemed necessary to complete the root canal procedure. I acknowledge and understand the positives and negatives (i.e., risks) related to the treatment for which I am agreeing to. I understand there is possibility that the current treatment plan may be altered once the root canal has been initiated which may include the following: pulpotomy, endodontic surgical procedures (apicoectomy), tooth removal (extraction), or no treatment. _____(initials)

I understand that I may choose not to move forward with the proposed treatment. I have been explained and further understand the risks of choosing not to continue with dental treatment. These risks could include but are not limited to pain, swelling, infection, further bone loss, and eventual tooth loss. It has been explained that root canal treatments are not 100% successful, as with any dental treatment or medical treatment, the results are not guaranteed. If the treatment is not successful, the tooth may have to be retreated, be treated with a surgical procedure, or be extracted. A deviation from the initial treatment plan could alter the costs; this has been fully explained, and I agree. _____ (initials)

I further understand that a root canal involves cutting some of the tooth structure in order to access the canal(s) and properly treat the tooth. I have been advised that I must contact my general dentist to obtain crown coverage immediately following the root canal completion. Should I fail to do so, I risk the possibility of fracturing the tooth. I agree to be compliant and responsible for my actions. _____ (initials)

Possible complications of treatment include, but are not limited to the following: procedural difficulties in the course of treatment, swelling, soreness, infection, trismus, paresthesia, discoloration of the adjacent soft or hard tissues, fractures of the crown or root of the tooth or restoration, separation of the root canal instruments during treatment, perforation of the root with instruments, and complications following anesthetic injection (e.g., hematoma, paresthesia, allergy, increased heart rate, etc.). _____ (initials)

I understand the definitive restoration (crown and/or filling) will be completed by my general dentist.

I certify that I have fully read and understand the above informed consent and agree to root canal treatment.

Patient Name: _____ Date: _____

Patient Signature: _____