



Consent for Endodontic Treatment

I, _____ understand root canal treatment is a procedure to retain a tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

I, the undersigned, have been informed that I require an endodontic procedure (root canal treatment on tooth # _____ and that I fully understand the following:

_____ Failure to follow this recommendation will most likely result in:

- A) The loss of the tooth.
- B) Bone destruction due to an abscess.
- C) Possible systemic (affecting the whole body) infection.

_____ A certain percentage (5-10%) of root canals fail, and they may require retreatment, periapical surgery, or even extraction.

_____ During instrumentation of the tooth, an instrument may separate and lodge permanently in the tooth or an instrument may perforate the root wall. Although this rarely occurs, such an occurrence could cause the failure of the root canal and the loss of the tooth.

_____ When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.

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

_____ Temporary fillings are usually placed in the tooth immediately after root canal treatment. Teeth which have had root canal treatment will require permanent (outside) restoration. This may involve a filling or more extensive restorative work (pins, pos, crown build-up, crown) depending on the clinical status of the tooth.

I understand that a series of appointments will be necessary to complete the root canal therapy as well as other appointments for restorations, I am also aware that I may have continuing temporary symptoms throughout the treatment. Those symptoms may include: swelling, pain, infection, drainage, fever, and numbness.

There are risks involved in the administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the Doctor of any previous side effects of allergies. Note: Antibiotics may decrease the effectiveness of birth control medication Additional methods of birth control should be used while on antibiotics.

Patient/Guardian Signature: _____

Date: _____

Witness to Signature: _____

Date: _____