PARISH DENTAL
Dental & Cosmetic Studio

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7-9 Branch Road, Armley, Leeds, West Yorkshire, LS12 3AQ

Informed Consent Form for Root Canal Treatment

Patient Name: _____

Date: _____

Procedure Description:

This consent form is to confirm that I, _____ [Patient's Name], understand that I am undergoing a root canal treatment. This procedure involves the removal of the infected or damaged pulp inside my tooth, cleaning and disinfecting the root canal, and then filling and sealing it to prevent further infection.

Potential Benefits:

1. Relief from symptoms such as pain and swelling.
2. Preservation of the natural tooth, avoiding the need for extraction and replacement.
3. Prevention of the spread of infection to other areas of the mouth.

Risks and Complications:

I acknowledge and understand that the procedure, like all dental procedures, involves risks and potential complications including, but not limited to:

1. **Post-Treatment Pain and Sensitivity:** Temporary discomfort or sensitivity in the treated area.
2. **Incomplete Procedure:** Rare cases where the root canal anatomy is complex or obstructed.
3. **Reinfection:** Risk of the treated tooth becoming reinfected.
4. **Tooth Fracture:** The tooth may become brittle and prone to fracture over time.
5. **Need for Additional Treatment:** Including possible retreatment, surgical intervention, or tooth extraction.

Alternatives to Root Canal Treatment:

I understand that alternatives to root canal treatment may include:

1. Tooth extraction, followed by options such as a dental implant, bridge, or denture.
2. Observation, accepting the risks associated with not treating the tooth.

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Consent:

I confirm that the dentist/endodontist has explained the root canal treatment, its risks, benefits, and alternatives to me, and has answered all my questions. I understand that no guarantees or assurances have been made to me concerning the results of this procedure. I consent to undergo root canal treatment as explained to me.

I also consent to the administration of local anesthetics and any other medications deemed necessary during the procedure. I understand the importance of following post-operative instructions to aid in my recovery.

Patient Signature: _____

Date: _____

Dentist/Endodontist's Signature: _____

Date: _____