FAMILY, IMPLANT & COSMETIC
DENTISTRY
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INFORMED CONSENT FOR ROOT CANAL THERAPY

In an attempt to increase patient awareness of the nature of endodontic therapy, it is requested that the patient read and acknowledge by signature the following statements.

I have been advised that I require root canal treatment for tooth #_____

The doctor has explained to me the method and manner of the proposed treatment, the desirability of root canal treatment compared to extraction and the consequences of not having root canal treatment including but not limited to the following:

1. Postoperative discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
2. Postoperative swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist several days or longer.
3. Infection that may require antibiotics.
4. Trismus (restricted jaw opening), which usually lasts several days but may last longer.
5. Failure rate of 5-10%. (If failure occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.)
6. Breakage of root canal instruments during treatment, which may, in the judgment of the doctor, be left in the treated root canal or require surgery for removal.
7. Perforation of the root canal with instruments, which may require additional surgical corrective treatment or result in premature tooth loss or extraction.
8. Premature tooth loss due to progressive periodontal (gum) disease in the surrounding area.

I understand that following root canal treatment my tooth may be brittle and must be protected against fracture by placement of a post and core and a crown (cap) over the tooth.

I understand that I am to return for a recall visit so that the doctor can evaluate the root canal treatment.

The doctor has answered all of my questions and I fully understand the above statements in this consent form.

_____ _____

Patient Name Date