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 of the alternatives to root canal treatment, including no treatment at all, I understand that if no treatment is provided I may experience:

1. The loss of the tooth;
2. Bone destruction due to an abscess.
3. Possible systemic (affecting the whole body) infection.

I also understand that if I choose to have root canal treatment for tooth no. ______:

1. A certain percentage (5-10%) of root canals fail, and they may require re-treatment, periapical surgery, or even extraction.
2. 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 event could cause the failure of the root canal and the loss of the tooth.
3. A root can crack or split which may affect the outcome of the root canal therapy
4. 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.
5. Successful completion of the root canal procedure does not prevent future decay or fracture.
6. Temporary fillings are usually placed in the tooth immediately after the root canal treatment. Teeth which have had root canal treatment will require a permanent (outside) restoration. This may involve a filling or more extensive restorative work (pins, post, crown buildup, crown) depending on the clinical status of the tooth.

There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the doctor of any previous side-affects of allergies from any medication.

*Note: Antibiotics may decrease the effectiveness of birth control medication. Additional methods of birth control should be used while on antibiotics.*

I agree that I have read, had explained to me and understand this consent for endodontic treatment. I have been given the opportunity to ask questions concerning the treatment, the risks of treatment and the alternatives to treatment. After fully considering this information, I hereby consent to endodontic treatment set forth above.

________________________  __________________________
Date                        Patient or Patient’s Guardian

________________________  __________________________
Date                        Signature of Witness