Informed Consent For Endodontic (ROOT CANAL) Treatment

PATIENT NAME____

TOOTH NAME/NUMBER____

Possible Complications which have been discussed with me include but are not limited to:

1. Possibility of separated instruments which may prevent successful treatment
2. Perforations (accidental openings) of the crown or root of the tooth
3. Identification of crown or root fracture during or after treatment
4. Damage to existing crowns, bridges, or other appliances
5. Root canal filling material which extends beyond the end or the root
6. Blocked root canals which may prevent successful treatment
7. Loss of tooth structure/weakening of tooth
8. Post-operative pain, swelling, and /or infection
9. A 5-10% chance of failure
10. Other: ____

The **benefits** of successful root canal treatment include the relief of pain and the ability to retain the tooth in comfort and function.

Treatment **alternatives** include: __________ No treatment __________ Extractions

Other ____

I understand that during treatment, complications may arise which complicate or make treatment more difficult, or which may require additional dental surgery.

I understand that root canal treatment weakens the crown of the tooth. The dentist has explained to me the need for a restoration which adequately protects the tooth after root canal treatment has been completed. I understand that no guarantee of success has been or can be given. All of my questions have been answered by the dentist and I fully understand all the above statements contained in this consent form.

______________________________________ ______________
Signature of Patient/Parent/Legal Guardian Date

_____________________________________ ______________
Signature of Dentist Date

_____________________________________ ______________
Signature of Assistant Date