SycamoreDentistree

ROOT CANAL THERAPY CONSENT FORM

I have been made aware of my condition requiring endodontic (root canal) therapy on tooth/teeth #(s) _____.

I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequences of doing nothing will lead to worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease and infection problems.

Some complications of root canal therapy may be, but are not limited to:
- Failure of the procedure necessitating re-treatment, root surgery, or extraction.
- Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer.
- Breakage of an instrument inside the canal during treatment, which may be left as is, or may require surgery for removal.
- Perforation of the canal with instruments, which may require additional surgical treatment or result in the loss of the tooth.

Successful completion of the root canal procedure does not prevent future decay or fracture or complications. An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chance of fracture.

By providing my signature, I certify that I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. I have had a chance to have all of my questions answered.

Signature:_____ Date:_____

Printed name: _____