

Root Canal Treatment Consent Form

Patient's Name: _____ Chart #: _____

TX Date: _____ Tooth No.: _____ Procedure: _____

Alternatives to Endodontic Treatment

Depending on my diagnosis, there may be alternatives to root canal treatment that involve other types of dental care. I understand the most common alternatives to root canal treatment are:

- **Extraction.** I may choose to have this tooth removed.
- **No treatment.** I may choose to not have any treatment performed at all. If I choose no treatment, my condition may worsen and I may experience severe pain, localized infections, loss of this tooth and the supporting bone, severe swelling, and/or severe infection.

Risks of Endodontic Treatment

- I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance. Some of the factors are: my resistance to infection; the bacteria causing the infection; the size, shape and location of the canals. My case may be more difficult if my tooth has blocked, curved or narrow canals.
- Root canal treatment may not entirely relieve my symptoms and treatment can sometimes fail for unexplained reasons. If treatment fails, other procedures (including re-treatment or surgery) may be necessary to retain the tooth or may have to be extracted.
- I may experience some pain or discomfort, during and after treatment, and possibly some swelling, bleeding and loosening of dental restorations. I may also need antibiotics to treat any associated infections.
- On rare occasions, root canal instruments sometimes separate (break) inside the canal which may or may not affect the prognosis. If the separated fragment cannot be retrieved, it may be sealed inside the root canal or require additional treatment in the future.
- I understand local anaesthetic will be given. Some discomfort following treatment may develop from the injection area and from opening my mouth during treatment. On rare occasions, paresthesia of the nerve may occur.
- Once root canal treatment is completed, I must have a permanent restoration placed by my regular dentist within a few weeks. If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture and/or possibly the loss of the tooth.

I acknowledge that I have provided an accurate medical history, will follow treatment recommendations and have had the opportunity to ask questions about these risks in continuing with root canal treatment.

Patient's Signature: _____ Date: _____