Informed Consent for Endodontic Treatment

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, as with all medical and dental procedures, it is a procedure in which results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally an unapparent, undiagnosed or hidden problem arises.

The procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had a root canal treatment may require re-treatment, endodontic surgery or tooth extraction.

RISKS (Are unlikely but may occur):
They include but are not limited to:

- Instrument separation in the canal
- Perforations (extra openings) of the canal with instruments
- Blocked root canals that cannot be ideally completed
- Incomplete healing
- Post-operative infection requiring additional treatment or the use of antibiotics
- Tooth and/or root fracture that may require extraction
- Fracture, chipping, or loosening of existing tooth or crown
- Post-treatment discomfort
- Temporary or permanent numbness
- Change in bite or jaw joint difficulty (TMJ problems or TMD)
- Medical problems may occur if I do not have the root canal completed
- Reactions to anesthetics, chemicals or medications used during the procedure

OTHER TREATMENT CHOICES:
The following other treatment options may be possible:

- No treatment
- Waiting for more definitive development of symptoms
- Extraction – to be replaced with either nothing, a denture, a bridge or an implant

Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture.

I have had the opportunity to ask questions of my treating doctor and I am satisfied with the answers that I have received. By signing below, I certify that I understand the recommended treatment, the risks of such treatment and any alternatives and the risks of these alternatives including the consequences of doing nothing.

Patient Name: _____ Tooth #: _____ Date: _____

Patient Signature (or Parent/Guardian) :_____

Treating Doctor : _____ Date : _____