



Informed Consent for Endodontic (Root Canal) Treatment

Date: _____ Patient Name & #: _____

Root Canal Treatment has been recommended for tooth(teeth) # _____ because of Pain; Infection; Decay; Other _____. This procedure requires making an opening through the chewing surface of the tooth, removing the pulp tissue, and filling & sealing the space with an inert rubbery material called gutta percha. Following root canal treatment, the tooth will require a final restoration, usually a crown. The final restoration is not part of this discussion. The intended benefit of this treatment is to relieve current symptoms and to retain the tooth root in the mouth. The prognosis for this procedure is _____.

The **risks** of Endodontic Treatment include pain, swelling, bleeding, changes in the bite, loss of dental restorations, infection, separation (breakage) of root canal instruments, perforation of the tooth, soft tissue injury, sinus involvement, and nerve disturbances such as temporary or permanent numbness, itching, burning or tingling of the lip, chin, teeth, or mouth tissues. These complications may result in the need for further treatment of a dental or surgical nature and/or loss of the tooth. A separated instrument may be sealed in the tooth, which may lessen the chance for clinical success.

Alternatives to endodontic treatment include extraction, or no treatment. These alternatives imply consequences including the need to replace missing teeth, continued or worsening infection and pain, and possible spread of infection to other areas of the body with serious health consequences.

I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand the injection areas may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

I have provided complete and accurate medical and personal history, including current medications, prescription and non-prescription, which I take, and any known drug allergies. I will follow all instructions as explained and directed to me, and will permit recommended diagnostic procedures, including X-rays. I realize that in spite of the possible complications & risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

I have been given the opportunity to ask questions regarding the benefit, risks, and alternatives of the procedure and have received satisfactory answers to all my questions. I understand that this procedure can also be performed by an Endodontist (a dental specialist), and that I may be referred to a specialist if unexpected difficulties occur. I wish to proceed with treatment by Dr. _____.

Signed: _____ (Patient or Guardian)

Signed: _____ (Treating Dentist)

Signed: _____ (Witness)