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CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Patient Name _____ Date _____

Procedure(s): Endodontic treatment of tooth name/number(s): _____

I have read and herby understand all of the associated risks of endodontic (root canal) treatment.

Please check as you read.

- ◯ Possibility of separated instruments which may prevent successful treatment.
- ◯ Perforation (accidental openings) of the crown or root of the tooth.
- ◯ Identification or crown or root fracture during or after treatment.
- ◯ Damage to existing crown, bridges or appliances.
- ◯ Root canal filling material which extends beyond the end or the root.
- ◯ Blocked root canal(s) which may prevent successful treatment.
- ◯ Loss of tooth structure/weakening of tooth.
- ◯ Post-operative pain, swelling, and/or infection.
- ◯ A 5-10% chance of failure.
- ◯ 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, extraction and/or other _____.

I understand that during treatment, complications may arise which complicate treatment 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 my questions have been answered by the dentist and I fully understand all the above statements contained in this consent form.

X _____ X _____
Signature (Patient/Parent/Legal guardian) Date

X _____ X _____
Signature (Dentist) Date