ENDODONTIC (ROOT CANAL)
INFORMED CONSENT

I, _____, hereby consent to the recommended endodontic treatment procedure(s) for myself (or my child if under age eighteen). I understand what my dental problem is and the reasons for the recommended treatment. Alternative treatments have been explained to me as well as the possible results if no treatment is performed. I also understand the possible consequences of not completing the endodontic treatment once it is initiated.

I understand that during, or after, endodontic treatment there is a possibility the following may occur: pain, swelling, infection, re-infection, cold sores, canker sores, irritation or injury to the oral tissues, periodontal involvement (loss of bone and/or tooth mobility due to infection). Separation of instruments (such as files) within the canal(s) of the tooth, calcified canals preventing enodontic therapy through the entire length of the root, perforation of the crown or root of the tooth (by dental instruments or as a pre-existing condition), and or allergic reactions to dental materials or medications.

I understand the root canal therapy is not always 100% successful and that the endodontic procedure(s) may have to be repeated and/or an additional minor surgical procedure may be required. I understand that the treatment may involve several appointments to complete the procedure(s).

I understand the after endodontic treatment; the tooth will require restorative treatment. I understand that although root canal treatment can save the tooth, the procedure may weaken the tooth, turn darker in color, or be more susceptible to fracture. Therefore, the tooth may require a crown upon completion of the endodontic treatment.

I hereby certify that I fully understand this authorization for endodontic treatment. I have been given the opportunity to ask questions and have been given satisfactory answers. I am aware that the practices of Dentistry and Endonontics is not an exact science, and acknowledge that no guarantees have been made as to the result of the procedure(s) authorized above.

_____ _____

Signature of patient or parent/guardian if a minor Date