ROOT CANAL TREATMENT INFORMED CONSENT

Patient Name:_____ Date:_____

Tooth Number: _____

I have been educated and informed regarding the root canal treatment for which I am giving my consent and I understand the risks that are involved in performing this procedure. Specifically, I have been informed that:

1. There is about five percent chance that my root canal therapy may not work. If the root canal fails, I may need additional treatment or the tooth may need to be removed. The fee charge for this root canal does not cover any additional treatment.
2. Any of the root canal instruments may break inside my tooth.
3. An instrument may create a hole, called a perforation, through the crown or root of the tooth.
4. A crown, bridge, veneer (cosmetic cover), natural crown, a dental restoration or my natural tooth may break of crack because of the root canal treatment.
5. The dentist may encounter complications which may include but are not limited to:

Blocked Canals
Split roots or fractured canals
Badly curved canal
Natural calcifications (hardening)
Periodontal damage or infection
Broken Instrument from a previous dentist's treatment or with our dentist.
Temporary or permanent nerve damage (my lip may remain numb even after the procedure)

Complications may make it impossible to complete the root canal. If is the case, I realize that there will be a fee for the time spent attempting the root canal.

6. I have the option of refusing treatment or of removing the tooth.
7. Any of the complication and problem may require me to have a additional treatment or surgery.
8. Teeth which require further treatment or re-treatment have a lower rate of success.
9. A tooth with root canal should have a permanent crown and I promise to return for this needed dental work.
10. I have been informed about the medications that the dentist has prescribed to me and of their possible complications. I will follow the dentist directions.
11. I agree to return promptly to have my root canal completed. I realize that if I fail to show up, or if I cancel future appointment and do not return, that I am still responsible for full fee of the procedure.
12. If I fail to show up for scheduled appointment, I take full responsibility for any serious consequences, such as hospitalization or death from infection, and hold the dentist harmless for my own acts.

Patient Initials:_____

I have had all my questions answered regarding his procedure and it's potential risk to me. I understand this consent form. I give permission to the dentist to do this procedure._____

Patient or guardian signature:_____

Dental staff signature:_____

Witnessed: _____