INFORMED CONSENT FOR ROOT CANAL TREATMENT

I_____ have been informed by Dr_____ that I require Root Canal Treatment for my tooth.

It has been explained to me the methods and manner of the proposed treatment, the alternatives to Root Canal Treatment and the possible complication, including, but not limited to the following:

1. Post-treatment discomfort lasting a few hours to several days for which medication may be prescribed if necessary.
2. Post-treatment swelling of the gum in the vicinity of the tooth, or facial swelling, either of which may persist for several days or longer.
3. Infection
4. Trismus (restriction of jaw opening) which usually lasts several days but may last longer.
5. Failure rate of 5%-10%. (If failure occurs the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted)
6. Breakage of the root canal instruments during treatment, which may, in the judgement of the dentists, be left in the treated root or require surgery for removal
7. Perforation of the root canal with instruments which may require additional corrective surgical treatment or result in premature tooth loss or extraction.
8. Premature tooth loss due to progressive periodontal (gum) disease in the surrounding or supporting area.

I understand that the tooth may be weakened following root canal therapy and may need to be supported by the placement of a crown (cap) over the tooth.

I understand that I may be advised to return in _____months for a follow-up radiograph to ensure that proper healing is taking place, and that failure to do so may result in loss of the tooth due to recurrent infection.

All of my questions have been answered by the dentist and I fully understand the above statements in this consent form.

Date:_____
Signature of Patient or Legal Guardian:_____