Practice Limited to Endodontics and Microsurgery

Consent for Root Canal Treatment

Patient's Name: _____

Condition Treated: _____

_____

_____

Proposed Treatment: _____

_____

_____

Root canal therapy is a procedure to retain a tooth, which may otherwise require extraction. The treatment involves relieving pain and discomfort by removing inflamed and/or infected tissue from within the roots of the teeth. Although root canal therapy has a very high degree of clinical success, many factors contribute to its success or failure, which may not be determined in advance. Therefore, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Some of these factors affecting outcome include, but are not limited to: the body's resistance to infection: the location and anatomy of the root canal system; periodontal (gum) disease; a tooth fracture that either went undetected or occurred after the treatment; failure to keep scheduled appointments; or the failure to have the tooth restored promptly or appropriately after completion of the treatment.

I understand that complications of endodontic therapy may include, but are not limited to: the possibility of instruments broken within the root canals which may deem the case a failure requiring subsequent extraction; perforations (extra openings) of the crown or root of the tooth; damage to existing fillings, crowns or bridges; fracture of the tooth; discomfort; jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty; swelling and pain. During and after treatment, complications may be discovered which make treatment impossible or which may require endodontic surgery or extraction of the tooth. This additional treatment may incur further fees as well.

I understand that complications of anesthesia, injection, prescribed

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analgesics (pain relievers) and medicines may include, but are not limited to: swelling, infection, bleeding, discoloration of the face, bruising, discomfort, pain, nausea, drowsiness, allergic reactions, numbness or tingling of the lip, gums or tongue (usually temporary).

I have been informed of possible alternative treatment methods including extraction or no treatment at all.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment and its alternatives, that you understand this information, and that all of your questions have been answered fully.

❑ I give my consent for the proposed treatment as described above.

❑ I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision and refuse treatment.

_____

Patient, Parent or Guardian / Date

_____

Dr. Mario Castro / Date