

INFORMED CONSENT FORM FOR ENDODONTIC TREATMENT (ROOT CANAL)

1. I, _____, hereby authorize and request that Dr. _____ and his assistants perform root canal therapy upon me with my consent.

2. Dr. _____ has explained to me that a root canal involves the use of a local anesthetic to numb the tooth and surrounding gum and bone. I understand that the administration of local anesthesia carries with it its own risks including but not limited to nerve damage, permanent numbness, discoloration, rashes, swelling, infection, and even in rare instances cardiac arrest. I also understand that after a local anesthetic is administered to me, Dr. _____ will then open the tooth to make access into the pulp or nerve chamber of the tooth, and that this may require Dr. _____ to drill through crowns, bridges, fillings, or tooth structure. I understand that once Dr. _____ gains access into the pulp or nerve of the tooth, that he will then, through the use of surgical instruments known as reamers, remove the pulp tissue or nerve in the root of the tooth, and that this also includes removing the blood supply and bacteria within the root system. After that, I understand that Dr. _____ will put in a substance called gutta percha after the tooth and root have been cleaned out and medicated and that this gutta percha will remain within the tooth and root structure of the tooth. After that, I understand that I will require a filling or a restoration which may consist of a simple filling and/or a crown and that this will be a permanent restoration for the tooth.

3. Dr. _____ has explained to me that the potential risks and complications to the root canal therapy include the following: swelling, sensitivity, pain, bleeding, infection, numbness and/or tingling sensation, either temporary or permanent in nature, involving the lips, cheeks, tongue, chin, gums, teeth, and jaw, changes in bite, jaw and muscle cramps and spasm,

temporomandibular jaw joint problems, myofascial pain dysfunction and muscular problems, trismus, sinus involvement, sinus perforation or hole, loosening or permanent damage of teeth, crowns, and bridges, referred complications resulting from the use of dental instruments such as separation, root perforation, fracture, or breakage of the reamer, retained reamer, and medications which carry with them their own inherent risks including allergic reactions, upset stomach, drowsiness, and coordination problems, and discoloration of the face.

4. I understand that root canal therapy is about 95 percent successful. Many factors influence the treatment outcome including the patient's general health, bone support around the tooth, strength of the tooth including possible fracture lines, shape and condition of the root(s) and nerve canal(s). I also understand that root canals do fail from time to time, and that that is a risk to the procedure. Should my root canal therapy fail, I understand that I would require a repeat root canal or even the possibility of the extraction of the tooth or teeth involved. I also understand that from a root canal, an abscess or infection, if any, may not be cured by the procedure. I understand that one of the risks from root canal includes, but is not limited to, the complication of my requiring an apicoectomy which could require me to undergo such a procedure whereby the root or roots of the tooth involved are also surgically removed.

5. I also understand that, with respect to a root canal, that the tooth is in a weakened state compared to a natural tooth. That makes the tooth subject to fracturing, or breaking. I also understand that a tooth, which has had a root canal, is still at risk for further decay and even infection.

6. Dr. _____ has explained to me the alternative treatments to root canal therapy including having no treatment at all, extracting the tooth, or teeth, and/or regularly monitoring the condition of the tooth. I understand that by doing nothing, I run the risk of developing a

severe infection, and losing the tooth. Dr. _____ has also explained to me that the risks involved with an extraction include, but are not limited to, infection, numbness, dry socket, and damage to the surrounding teeth, gums, bone, muscles, and restorations. I reject these alternative treatments and request that Dr. _____ perform root canal therapy upon me.

7. I understand that, while Dr. _____ is attempting to perform the root canal therapy, there may be severe curvatures of the roots of the teeth or calcifications within the teeth, which may cause Dr. _____ to be unable to complete or perform the root canal therapy. I understand that some teeth may not be amenable to endodontic treatment. I nevertheless authorize him to perform the root canal therapy.

The nature of root canal therapy has been explained to me and I have had a chance to have all of my questions answered. I understand that dentistry is not an exact science and that Dr. _____ has not guaranteed the success of root canal therapy. In light of the above, I hereby authorize Dr. _____ to proceed with the root canal therapy.

Date: _____

Patient:

Witness: _____

Guardian:
