NON-SURGICAL ENDODONTIC THERAPY INFORMED CONSENT

I understand that root canal therapy is a treatment performed to retain a tooth which might otherwise require extraction. Root canal treatment removes the pulp tissue (nerves and blood vessels) inside a tooth, then seals the space with a filling material. During root canal therapy, certain procedural complications can occur including, but not limited to, temporary or permanent alteration of sensation, i.e., numbness, separated instruments, blocked canals, root perforations, and damage to restorations. A patient may experience post-operative discomfort or swelling and may require medications for several days. Although root canal therapy has a high degree of success, it is still a biological procedure, and as such, cannot be guaranteed. Some teeth with root canal therapy may require further treatment, surgery, or even extraction.

Local anesthetics will be used during root canal therapy. Some common side effects include pain, swelling, and bruising. Other rare side effects may include convulsions, weakness, allergic reactions, persistent numbness, stiffness in the jaw joint(s) or muscle (trismus), and injury to blood vessels or nerves.

I further understand that many factors contribute to the success or failure of root canal therapy that cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed or may fail following treatment. Some of these factors include, but are not limited to, my resistance to infection, the shape and location of the canal anatomy, my failure to keep scheduled appointment(s), the failure of my having the tooth restored following the treatment, periodontal (gum) involvement, or an undetected or an “after-the-fact” fracture in the tooth.

Alternative treatment options include no treatment, waiting for more definitive symptoms to develop, or tooth extraction.

I understand that only root canal therapy will be performed in this office. A subsequent restoration (filling, crown, etc.) will be needed and will be performed by my general dentist.

Tooth Treated____________________________

Signed By____Date__________________
patient, parent, guardian (please circle)

Signed By_______________________________________Date_______________________
Doctor