TREND DENTAL
FAMILY DENTISTRY

INFORMED CONSENT FOR ROOT CANAL TREATMENT

This is my consent for the dentist to perform the recommended Root Canal Treatment as previously explained to me, or other procedures deemed necessary or advisable to complete the planned procedure.

Tooth Number(s): _____

Location: _____

What is Endodontic Treatment?

Endodontic Treatment ("Endodontic" means within the tooth) is the treatment of the pulp chamber and canals that lies in the middle of the tooth and its roots. When completed, an endodontically treated tooth generally functions and feels just like your other teeth and have excellent chance of remaining in your mouth for as long as your other teeth.

Endodontic Treatment is done using Local anesthetic to numb the tooth. Access is gained to the canals by drilling a small hole in the top or back of the tooth followed by removal of the diseased nerve tissue, cleaning and shaping of the pulp canals, and filling the canals with an inert filling material. A temporary filling is then placed in the access opening.

Purpose of the Treatment:

The goal of Root Canal Treatment is twofold:

1. To destroy and remove bacteria and diseased nerve tissue within the roots and
2. To seal the resulting empty canals to prevent further bacterial growth and leakage.

Risks of the Treatment:

While Endodontic Treatment is considered safe and effective, there are potential risks of having root canal treatment:

1. I understand that root canal treatment may not relieve my symptoms and treatment can sometimes fail for unexplained reasons. If treatments fail, other procedures (including retreatment by a specialist) may be necessary to retain the tooth or may have to be extracted.
2. I understand that during and after treatment, I may experience some pain or discomfort, swelling, bleeding, and loosening of dental restorations. I may also need antibiotics to treat any associated infections.

3. I understand that root canal instruments sometimes separate (breaks) inside the canal which may or may not affect the prognosis and a referral to a Specialist may be required.
4. I understand occasionally perforation of the root with instruments or root fracture from the pressure of filling may result in the need for surgical corrective treatment or extraction of the tooth.
5. I understand occasionally, the canals are calcified or blocked, preventing sealing of the root end. Similarly, instruments tips occasionally break off within the canal preventing sealing of the root end. In such cases, if a good seal cannot be established, root tip surgery or referral for extraction may be required.
6. I understand after endodontic treatment a permanent restoration or crown should be placed as soon as possible. **Failure to have a permanent restoration placed within 6 weeks following root canal treatment may result in leakage of the temporary restoration and reinfection of the root canal (requiring retreatment of the root canal) or Failure to have a crown placed may result in fracture of the tooth (often requiring extraction).**

Alternative to Endodontic Treatment:

Based on the diagnosis, there may be alternatives to root canal treatment that involve other types of dental care. I understand the most common alternatives to root canal treatment are:

- **Extraction:** I have been given the option to have this tooth removed. The extracted tooth usually requires replacement by artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- **No treatment**: I have been told no treatment is an option. I am aware that if no treatment, my condition may worsen. Including localized severe pain, localized infections, loss of this tooth and possible other teeth, severe swelling, an/or severe infection that may spread to other areas and could be potentially fatal.

Informed Consent:

I have read this entire form and understand everything explained in it. I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I voluntarily assume all possible risks including those listed in this form. I understand no guarantees or promises have been made to me concerning the results and the fee(s) for service have been explained to me and are satisfactory. I accept all financial responsibility for this treatment.

By signing this document, I am freely giving, my consent to allow and authorize Dr._____ to render any treatment necessary and/or advisable to my dental needs including the prescribing and administering of any medications and/or anesthetics deemed necessary to my treatment.

I authorize Dr._____ to perform the proposed root canal treatment.

_____RETENTION OF DOCUMENTS RELATING TO YOUR CARE AND AGREEMENT. By signing
(Initial)
this, you understand and agree that it is our policy to scan original documents and store documents in an electronic form. Further, you agree that any agreement bearing scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

Patient's Name (Printed): _____Date: _____

Patient's Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

Witness's Name: _____ Witness's Signature: _____ Date: _____