Informed Consent Form – Root Canal Therapy

DIAGNOSIS:

Your oral examination, dental x-ray and your symptoms tell us that your tooth requires root canal therapy.

RECOMMENDED TREATMENT:

We have recommended having the tooth treated by endodontic therapy, which consists of removal of the material within the root canal of the tooth and the replacement of that material by inert filler. Possible complications: pain, post-operative swelling could occur and since the tooth could become brittle during or following therapy, there is a possibility of tooth fracture and/or loss. We are not responsible for any breakage of the tooth during or after endodontic treatment. After endodontic treatment is finished, a core and crown restoration is recommended in order to protect the tooth.

TREATMENT CONSIDERATIONS:

An alternative treatment plan would be to extract the tooth and if possible, replacement with fixed bridge implant or partial denture. The cost of final restoration is not included in the cost of the root canal therapy.

CONSEQUENCES OF NON-TREATMENT:

If treatment is not performed, swelling or infection could occur and such infection could damage adjacent teeth or the tooth in question may require extraction.

Patient Initials:_____

EXTENDED PROGNOSIS:

Root canal therapy is not 100% of the time. Re-treatment and/or root therapy might be necessary in the future. In fact, with some teeth conventional root canal therapy alone may not be sufficient. For example, if the canal(s) is severely bent or calcified; if there is a substantial or long standing infection in the bone around the roots; if a metal file becomes separated within a canal, the tooth may remain sensitive and a surgical procedure may be necessary to resolve the problem. If root canal surgery is later anticipated, you should understand the possible sequels of surgical treatment, which include possible pain and immobility for a few days, bleeding, swelling, bruising, minor infection, temporary or permanent anesthesia of the lip, chin or tongue, as well as possible sinus perforation. File breakage is a known risk of root canal therapy. During endoodontic treatment we will reduce the height of your tooth to prevent pain when you close your teeth together.

EMERGENCY ARRANGEMENTS:

Should you have a problem, please call 403-262-2627.

Dr._____ is not an Endodontist (a certified specialist in endodontics). If we feel your root canal therapy requires skills beyond our training, we will refer you to a specialist.

CAUTION: FOR A PATIENT WHO WEARS A HEART PACEMAKER OR HAVE ANY KIND OF ALLERGY: PLEASE ADVISE THE DENTIST OF THIS CONDITION OR ANY OTHER AILMENT SO THAT THE PROPER PRECAUTIONS CAN BE TAKEN.

Patient Initials: _____

Consent For Root Canal Therapy And/Or Surgery

This will acknowledge that I have provided to you sufficient knowledge regarding your treatment and/or surgery requirements in order that you may make an informed decision. I have attempted to explain fully the advantage and disadvantages of your root canal treatment and/or surgery. Before consenting to the procedure, your must understand that each individual reacts differently and that dentistry, as in medicine, is not an exact science and therefore no guarantee can be made or implied as to the success of the root canal treatment and/or surgery. Numbness could occur due to damaged or bruised nerves during your root canal treatment and/or surgery. Before proceeding, I will ask you to read, understand and sign the consent form which follows:

I_____, am of adult age and capable of signing this consent. I have consulted with Dr._____ because I seek his/her services for my root canal needs and/or surgery. I acknowledge that the dentist has carefully examined my mouth, discussed treatment and/or oral surgery with me and has answered all of my questions. I feel that I am adequately informed as to the procedure, so I can give my informed consent hereto.

Patient's Signature:_____ Date:_____

Witness: _____ Date:_____