



Root Canal Treatment Consent Form

Patient's Name: _____ TX Date: _____ Tooth #: _____

Risks of Endodontic Treatment:

- I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance. Some of the factors are my resistance to infection; the bacteria causing the infection; the size, shape, and location of the canals. My case may be more difficult if my tooth has blocked, curved, narrow, or calcified canals.
- I understand that root canal treatment may not relieve my symptoms and that treatment can sometimes fail for unexplained reasons. If treatment fails, other procedures (including re-treatment or surgery) may be necessary to retain the tooth or may have to be extracted.
- 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.
- I understand that root canal instruments sometimes separate (break) inside the canal which may or may not affect the prognosis. If the separated fragment cannot be retrieved, it may be sealed inside the root canal or require additional treatment in the future.
- I understand that other risks include perforation by the instrument, sinus perforation and/or nerve disturbances.
- I understand local anesthetic will be given. Some discomfort following treatment may develop from the injection area and from opening my mouth during treatment. On rare occasions, paresthesia of the nerve may occur.
- I understand that once root canal treatment is completed, I must have a permanent restoration placed by my regular dentist within a few weeks. If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture and/or loss of the tooth.



Alternatives to Endodontic Treatment:

Depending on my 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 may choose to have this tooth removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- No treatment. I may choose to not have any treatment performed at all. If I choose no treatment, my condition may worsen and I may risk serious personal injury. Including severe pain, localized severe pain, localized infections, loss of this tooth and possible other teeth, severe swelling, and/or severe infection that may spread to other areas and could potentially be fatal.

I acknowledge that I have provided an accurate medical history, will follow treatment recommendations, and have had the opportunity to ask questions about these risks in continuing with root canal treatment.

Patient's Signature: _____	Date: _____
Parent/Guardian: _____	Date: _____
Provider's Signature: _____	Date: _____