FAMILY DENTAL CENTRE

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INFORMED CONSENT

Endodontic (Root Canal) Treatment

I have been made aware of my condition which is: _____
and requires endodontic (root canal) treatment in the opinion of Dr._____who is a General Dentist. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequence of no treatment may cause further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease problems.

Some complications of root canal treatment may be, but are not limited to:

- Failure of the procedure necessitating re-treatment, root surgery, or extraction.

- Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer.

- Breakage of an instrument inside the canal during treatment, which may be left as is, or may require treatment by a specialist for removal of the instrument.

- Perforation of the canal with instruments which may require additional treatment by a specialist or result in the loss of the tooth.

- Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of lip, chin, tongue, or other areas.

Successful completion of the root canal procedure does not prevent future decay or fracture. An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chances of fracture.

I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me, and I have had a chance to have all of my questions answered.

DATE:_____ PATIENT'S NAME:_____

PATIENT OR GUARDIAN'S SIGNATURE:_____