DOVE DENTAL
SPECIALISTS

Root Canal Therapy Consent Form

1. **WORK TO BE DONE**
   - I understand that I am having the following work done: _____
2. **DRUGS AND MEDICATIONS**
   - I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting and/or anaphylactic shock (severe allergic reaction)
3. **CHANGES IN TREATMENT PLAN**
   - I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being Root Canal Therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, as with all medical and dental procedures, it is a procedure whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally an unapparent, undiagnosed or hidden problem arises.

This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had root canal treatment may require re-treatment, endodontic surgery, or tooth extraction.

Risks: Are unlikely, but may occur. They might include but are not limited to:

a) Instrument separation in the canal.

b) Perforations (extra openings) of the canal with instruments.

c) Blocked root canals that cannot be ideally completed.

d) Incomplete healing.

e) Post-operative infection requiring additional treatment or the use of antibiotics.

f) Tooth and/or root fracture that may require extraction.

g) Fracture, chipping, or loosening of existing tooth or crown.

h) Post-treatment discomfort.

i) Temporary or permanent numbness.

j) Change in the bite or jaw joint difficulty (TMJ problems or TMD).

k) Medical problems may occur if I do not have the root canal completed.

l) Reactions to anesthetics, chemicals or medications.

Other Treatment Choices: The following other treatment options might be possible:

a) No treatment at all.

b) Waiting for more definitive development of symptoms.

c) Extraction: To be replaced with either nothing, a denture, a bridge or an implant

After the completion of the root canal procedure, we recommend returning for your permanent restoration (filling, crown, cap). Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture. I have had an opportunity to ask questions of my treating doctor and I am satisfied with the answers that I have received.

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment and all questions have been answered to my satisfaction.

Patient Name: _____

Email: _____ Phone: _____

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____

Printed Name of Patient, Parent, Guardian, or Personal Representative