

ROOT CANAL TREATMENT CONSENT FORM

I have been made aware of the diagnosis for the tooth_____and been advised the need for endodontic (root canal) treatment in the opinion of my dentist Dr_____

Root Canal Treatment is designed to attempt to salvage a tooth or the root of a tooth because infected tooth act as a reservoir of bacteria in the mouth which can result in an abscess

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 consequences of doing nothing will lead to worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease and infection problems.

Some complications of root canal therapy 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 surgery for removal
- Perforation of the canal with instruments, which may require additional surgical treatment or result in the loss of the tooth

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

Pls note: Root canal treatment in a tooth/teeth with complex root anatomy may require referral to a Specialist Endodontist who can carry this treatment out for you. They work on a fully private basis and their charges vary from clinician to clinician. If you wish to have the treatment completed by a Specialist, then your dentist can arrange a referral to a local endodontist as soon as possible.

By providing my signature, I certify that I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. I have had a chance to have all of my questions answered

Signature:

Date:

