Discussion and Consent for Root Canal Treatment

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Patient's Name _____ Date of Birth _____
Last First Initial

I am being provided this information and consent form so I may better understand the treatment recommended for me. Before beginning, I want to be provided with enough information, in a way I can understand, to make a well-informed and confident decision regarding my proposed treatment.
I understand that I may ASK ANY QUESTIONS I WISH, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Endodontic Treatment
Root canal treatment has been recommended for me on the following tooth (teeth): _____.

Root canal treatment (also called endodontic treatment) requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root(s). It is done by first making an opening through the chewing surface of the tooth to gain access to the tooth's pulp. The contents of the canals are removed and the canals cleaned and shaped. The canals are then filled and sealed with an inert, rubbery material called gutta percha. Following root canal treatment, the tooth will need a final restoration, usually a crown, to return it to proper function. The final restoration is not part of this discussion and consent.
This recommendation is based on visual examination(s), on any x-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wants have also been taken into consideration. Root canal treatment is necessary because of:

☐ Pain ☐ Infection ☐ Decay ☐ Broken Tooth/Teeth ☐ Other _____

The intended **benefit** of root canal treatment is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed. Root canal treatment also retains the tooth root in my mouth, permitting the tooth to be restored to proper function.

The prognosis, or chance of success, of this root canal treatment is _____.

My root canal treatment is estimated to cost $_____ and estimated to take _____ visit(s) to complete.

Alternatives to Endodontic Treatment
Depending on my diagnosis, there may or may not be alternatives to root canal treatment that involve other types of dental care. I understand the two most common alternatives to root canal treatment are:

- Extraction. I may choose to have 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 infection; loss of this tooth and possibly other teeth; severe swelling; and/or severe infection that may be potentially fatal.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have
Patient's Initials heard or thought about, including _____.

Risks of Endodontic Treatment
♦ I have been informed and fully understand that there are certain inherent and potential risks associated with root canal treatment. I understand that during and after treatment I may experience pain or discomfort, swelling, bleeding, changes in my bite, and loosening or loss of dental restorations. I understand that it is possible for an infection to occur or an existing infection to worsen in the tooth being treated and/or in the area around the tooth, and that I may need antibiotics and/or other procedures to treat the infection.

Patient: _____

- I understand that root canal instruments sometimes separate (break) inside the canal. This is more likely when canals are curved and/or narrowed. If the separated fragment cannot be retrieved, it may need to be sealed inside the root canal. It may also be necessary to have oral surgery performed on the tooth root (apicoectomy) to address the problem. I understand that a separated instrument often decreases the likelihood of clinical success.
- I understand that other risks include: perforation of the tooth or tooth root by an instrument; injury to soft tissues adjacent to the tooth; sinus perforation; and nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.
- I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance, if ever. Some of the factors are: my resistance to infection; the specific bacteria causing the infection; the size, shape, and location of the canals; the force with which I bite. I understand that my case may be more difficult if my tooth has blocked canals, curved canals, or very narrow canals.
- I understand that root canal treatment may not relieve my symptoms, that treatment can fail during or after completion of treatment; and that it may fail for unexplainable reasons. If treatment fails, other procedures (including root canal retreatment and/or oral surgery) may be necessary to attempt to retain the tooth, or it may have to be extracted.
- I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.
- I understand that once root canal treatment is completed, I must promptly return to begin the next step in treatment. If I fail to return to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth.
- Other foreseeable risks not stated above include: _____

_____ **Patient's Initials** I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including _____.

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I realize that in spite of the possible complications and risks, my recommended root canal treatment is necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the treatment.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

I wish to proceed with the recommended treatment.

_____ **Patient's Initials** I understand this treatment can also be performed by an endodontist (a root canal specialist). I understand the risks and elect to have this procedure done by Dr. _____. I understand that if any unexpected difficulties occur during treatment, I may be referred to an endodontist for further care of this tooth.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness