

INFORMED CONSENT DISCUSSION FOR ROOT CANAL TREATMENT:

Patient Name: _____ Date of Birth: _____

DIAGNOSIS: _____

Facts for Consideration

(Patient's Initials Required)

- _____ Root canal treatment (also called endodontic treatment) involves removing the nerve tissue (called pulp) located in the center of the tooth and its root or roots (called the root canal). Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp, which then are removed. Medications may be used to sterilize the interior of the tooth to prevent further infection. Root canal treatment may relieve symptoms such as pain and discomfort. If any unexpected difficulties occur during treatment, you may be referred to an endodontist, who is a specialist in root canal treatment.
- _____ Each empty root canal that can be located is filled. Occasionally, a post is also inserted into the canal to help restore the tooth. The opening in the tooth is closed with a temporary filling. At a later appointment, a crown may be placed. It is a separate dental procedure not included in this discussion.
- _____ Twisted, curved, blocked, or accessory canals may prevent removal of all inflamed or infected pulp. Since leaving any pulp in the root canal may cause your symptoms to continue or worsen, this may require an additional procedure called *apicoectomy*. Through a small opening cut in the gums and surrounding bone, any infected tissue is removed and the root canal is sealed. An *apicoectomy* may also be required if your symptoms continue and your tooth does not heal.
- _____ Once the root canal treatment is completed, it is essential to return promptly to begin the next step of the treatment. Because a temporary seal is designed to last only a short time, failure to return as directed to have the tooth sealed permanently with a crown or filling can lead to other problems such as deterioration of the seal, resulting in decay, infection, gum disease, fracture, and possible permanent loss of the tooth.

Benefits of Veneers, Not Limited to the Following:

- _____ Root canal treatment is intended to allow you to keep your tooth for a long time, which will help maintain your natural bite and healthy functioning of your jaws. This treatment has been recommended to relieve the symptoms of the diagnosis described above.

Risks of Veneers, Not Limited to the Following:

- _____ **I understand** that following treatment, I may experience bleeding, pain swelling and discomfort for several days, which may be remedied with pain medications. It is possible infection may accompany root canal treatment and must be treated with antibiotics. I will immediately contact the office if conditions worsen or if I experience fever, chills, sweating, or numbness.
- _____ **I understand** that holding my mouth open during treatment may temporarily leave my **jaw feeling stiff and sore** and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. **I must notify your office** if this or other concerns arise.
- _____ **I understand** that all **medications** have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking which are:

_____ **I understand** that I will receive **local anesthetic and/or other medication**. In rare instances patients may have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the normal chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a **designated driver to take me home**. Rarely, temporary or permanent nerve injury can result from an injection.

_____ **I understand** that during treatment, the root canal filling material may extrude out of the root canal into the surrounding bone and tissue. Occasionally, an *apicoectomy* may be necessary for retrieving the filling material and sealing the root canal.

_____ **I understand** that occasionally, a root canal instrument may break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment may be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical stainless steel, so this usually causes no harm). It may also be necessary to perform an *apicoectomy*, as described above, to seal the root canal.

_____ **I understand** teeth that received root canal treatment may be more prone to cracking and breaking over time, which may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal treatment may not relieve all symptoms. The presence of gum disease (periodontal disease) can increase the chance of losing tooth even though the root canal treatment was successful.

_____ **I understand** that root canal treatment may not relieve my symptoms, and I may need my tooth extracted.

_____ **I understand** that although it is impossible to guarantee perfect results, every reasonable effort will be made to ensure the success of my treatment.

Consequences if No Treatment Is Administered, Not Limited to the Following:

_____ **I understand** that if I do not have **root canal treatment**, my discomfort may face the risk of a serious, life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually, the loss of my tooth and/or adjacent teeth.

Alternative to Root Canal, Not Limited to the Following:

_____ **I understand** that depending on the diagnosis, alternatives to root canal treatment may exist which involves other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an *implant*. I have asked my dentist about the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.
Alternatives discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I consent to the veneer preparations and placement as described above by Dr. _____

I refuse to give my consent for the proposed treatment as described above.

I have been informed of and accept the consequences if no treatment is administered.

Patient / Representative Name and Signature

Date

Witness Signature

Date

FOR DENTIST USE ONLY:

I attest that I have discussed the risks, benefits, consequences, and alternatives to Root Canal Treatment with: _____ (patient name) who has had the opportunity to ask questions, and I believe my patient understand what has been explained.

Dentist Signature

Date