CONSENT FOR ENDODONTIC (ROOT CANAL) THERAPY

I hereby consent to endodontic treatment on tooth number(s) _____
I understand that the tooth is infected or the nerve has been exposed to decay and I understand the reasons for the treatment. (removal of infection or the exposed nerve to prevent reinfection) The alternative treatment for this tooth/teeth would be extraction and has been explained to me as well as the consequences of no treatment. I understand the possible consequences of not completing treatment- once it is initiated.

I understand that during or after treatment there is a possibility the following may occur: swelling, infection, reinfection, pain, cold sores, canker sores, irritation or injury to the oral mucosa, periodontal involvement, instrument breakage in the canal, ca;cified canals preventing therapy perforation on the crown or root, allergic reaction, prolonged tenderness and sensitivity. I understand that root canal therapy is not 100% successful. (about 95% successful) and that may have to be repeated and/or additional surgical procedure(s) may be required. I understand that treatment may involve several appointments to complete. I understand that although root canal therapy can save a tooth from needing to be extracted, the procedure weakens the tooth and causes it to become more brittle, turn dark in color, and more susceptible to fracture. I understand that after treatment, the tooth will require a crown restoration.

I understand this authorization. I have been given the opportunity to ask questions and have been given satisfactory answers to my questions. I understand that this procedure can also be performed by a specialist and I prefer that it be performed in this office by a general dentist. No guarantees have been made to me.

Patient Name_____ Date_____

Patient Signature _____

Witness Signature_____