

Informed Consent for Root Canal Therapy

I am being provided with this information and consent form so I may better understand the treatment recommended for me.

Nature of Endodontic Treatment

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 material. 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, on other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wishes also have been taken into consideration.

Reason for Root Canal Treatment _____ **Tooth #** _____

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 likelihood of success, of this root canal treatment is: **excellent** **good** **fair** **poor**

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:

- ⌚ 1. Extraction I may decide to have the tooth removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- ⌚ 2. No treatment I may decide not to have any treatment performed at all. If I decide upon not having the recommended 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 is rarely but potentially fatal. I have had an opportunity to ask questions about these alternatives.

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. I understand that root canal instruments sometimes break inside the canal. This is more likely when canals are curved and/or narrowed. If the broken fragment cannot be retrieved, it may require sealing inside the root canal. It also may be necessary to have oral surgery performed on the tooth root (apicoectomy) to address the problem. I understand that a broken 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; chemical damage to tissues from disinfecting products; 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.

Acknowledgment

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 the Doctor 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, the risks of the recommended treatment, and the risks of refusing treatment. I wish to proceed with the recommended treatment. I understand this treatment can also be performed by an endodontist (a root canal specialist). I understand that if any unexpected difficulties occur during treatment, I may be referred to an endodontist for further care.

I understand the risks and elect to have this procedure performed by _____ Dr. Edward Gracza _____ Dr. Jane Gracza _____ Dr. Jon Hallie

Signature of Patient or Guardian

Date

Signature of Treating Dentist

Date

Witness

Date

