ENDODONTIC (ROOT CANAL) INFORMED CONSENT

1. The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted.
2. Treatment may require multiple visits. It is important that you maintain scheduled appointments for infection control.
3. In most cases, there is only mild discomfort following each treatment. This is usually controlled with aspirin, Tylenol, ibuprofen, or prescribed medication.
4. Endodontic treatment has a high degree of success. However, as with any medical or dental treatment, this treatment may be compromised due to chronic infection. Teeth with previous root canal treatment will have a lower success rate.
5. Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment.
6. The most common complications with root canal therapy include, but are not limited to:
   - A. Continued infection requiring endodontic (root canal) surgery or extraction of the tooth.
   - B. Calcified canals or canals blocked by broken instruments requiring endodontic (root canal) surgery or extraction of the tooth.
   - C. Pain, requiring use of medication.
   - D. Side effects and reactions to medication.
   - E. Fractures (breaking) of the root or crown of the tooth during or after treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Your general dentist will make the final determination as to whether the crown can be saved. Porcelain crowns are subject to breakage.
   - F. Tenderness of the tooth following treatment due to possible complications with the root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits.
7. Other treatment choices include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.
8. If you have any questions, please ask.

"I HAVE READ AND UNDERSTAND THE ABOVE, AND HEREBY CONSENT TO TREATMENT"

Patient Name	Signature of Patient, Parent, or Guardian	Date
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