Informed Consent for Endodontic Treatment (Root Canal)

I, _____, authorize Dr. Aboushala/Dr. Shlosman to perform non-surgical endodontic treatment/or retreatment on tooth #_____. I understand that root canal therapy is a procedure designed to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of success (over 90%), it is a biological procedure whose results therefore cannot be guaranteed. Further, root canal therapy is performed to correct an apparent problem and occasionally, undiagnosed or hidden problems may arise. I understand that this procedure will not prevent future tooth decay or possible fracture and that occasionally, a tooth that has had root canal treatment may require re-treatment, root surgery or tooth extraction.

The treatment has been fully explained to me including involved risks. I have been informed that complications might include, but are not limited to perforation, of the canal(s) with instruments, instrument separation in the canal(s), incomplete healing following treatment, post-operative discomfort and/or infection, prolonged aesthesia and/or paraesthesia associated with local anesthetic injections and/or extruded endodontic cement beyond root apices, tooth and/or crown fracture.

I understand that there are alternatives (with associated risks) to root canal therapy. They include, but are not limited to:

A.) No treatment. My present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to pain, swelling, infection, loss of supporting bone around the teeth, premature loss of tooth/teeth and possibly systemic involvement.

B.) Extraction with nothing to fill the space. This may result in the shifting of teeth, change in bite, periodontal disease and TMJ problems.

C.) Extraction followed by bridge, partial denture or implant to fill the space.

<u>Final restoration of a tooth that has undergone root canal therapy is essential to root canal success and retention of the tooth. A final restoration should be completed within 30 days of root canal therapy. This restoration should be placed by my restorative dentist.</u>

I have had the opportunity to ask questions of my doctor, and I am fully satisfied with the answers that I have received. I consent to endodontic treatment.

Patient: _____Date: _____

Guardian: _____Date: _____

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