Snowy River Dental
FAMILY & COSMETIC DENTISTRY

Endodontic/Root Canal Therapy Consent Form

I have been advised by my dentist that I require root canal treatment on my **tooth #___** , described as _____.

I understand that root canal treatment is an attempt to save my tooth. The only alternative treatment is extraction.

I have discussed the root canal treatment procedures with my student dentist and I understand that the following risks and complications may arise:

1. Local anesthesia injections sometimes cause pain, swelling, difficulty in opening my mouth and/or paresthesia (temporary or permanent loss of feeling).
2. Post-operative discomfort or swelling may occur for which medication may be prescribed if deemed necessary by the dentist.
3. Allergic reactions to medications or anesthetics may occur for which additional treatment or medications may be required.
4. Separation of sterile root canal instruments during treatment may occur which may or may not affect treatment outcome. It will be the judgment of my dentist to determine if the separated instrument is to be left in the root canal or if surgical procedure(s) for removal is required.
5. Perforation of the root canal may occur. This may require additional treatment, surgical repair or extraction.
6. Premature tooth loss may result from cracks or fractures that can occur during or after the root canal treatment.
7. Access to the root canals through a crown, bridge, any type filling (existing restorations), etc. will result in necessary repair or replacement of the restoration. This necessary repair is a consequence of root canal treatment and not a fault by my dentist.
8. Treatment may be discontinued by at any time by my dentist due to calcified canals, fracture of the tooth or its root(s) or additional problems uncovered during the root canal treatment.
9. Success rate of root canal treatment is very high: 90-95%. However, since root canal treatment is a biologic procedure, **results cannot be guaranteed**.
10. The crown of the tooth may darken or become brittle as consequences of root canal treatment. It is recommended that a proper restoration be placed as soon as possible.
11. I understand that medications may be prescribed that may have side effects, to include but not limited to, nausea, dizziness, drowsiness, diarrhea, or allergy (itching, rash, hives or difficulty breathing). It is my responsibility to call immediately if the above side effects occur.
12. I understand that I may discontinue the root canal treatment; however, failure to continue with initiated root canal treatment may result in the loss of my tooth, pain, swelling, abscess and / or infection. I cannot hold the dentist responsible for my discontinuation of treatment.
13. I understand that doing root canal treatment through crowns may hide existing decay or cracks that are not visible to the dentist with direct vision, on x-rays or by probing.
14. I understand that root canal treatment is not considered complete until I have the proper restoration placed on the tooth.

The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, the parent with the authority to give consent or legal guardian of the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

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Patient's Signature (Signature of Parent/Guardian) **Date**