LOVE YOUR SMILE
FAMILY & AESTHETIC DENTISTRY

Patient Initial

DISCUSSION & CONSENT FOR ROOT CANAL TREATMENT

Patient's Name: _____ Date of Birth: _____

Nature of Treatment

Root canal treatment has been recommended for me on the following tooth/teeth: _____

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 diagnostic imaging, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been considered. Root canal treatment is necessary because of:
☐ Pain ☐ Infection ☐ Decay ☐ Broken tooth/Teeth ☐ Other: _____.

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 procedure is _____.

My root canal treatment is estimated to cost $_____ and is estimated to take _____ visit (s) to complete.

Alternatives

Depending on my diagnosis, there may or may not be an alternative to root canal treatment that involves other types of dental care. I understand that the two most common alternatives to root canal treatment are:

- Extraction. I may decide to have tooth # _____ removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- 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 may be potentially fatal.

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,

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Discussion & Consent for Root Canal Treatment (page 2)
Risks of Endodontic Treatment (continued)

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 separate (break) inside the canal. This is more likely when canals are curved and/or narrowed. If the separated 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 separated 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; 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.

I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance, if ever. Some of the factors include but are not limited to: my resistance to infection; the specific bacteria causing the infection; the size, shape, and location of the canals; the force with which I bite. I understand that my case may be more difficult if my tooth has blocked canals, curved canals, or very narrow canals. I understand that root canal treatment may not relieve my symptoms, that treatment can fail during or after completion of treatment; and that it may fail for unknown reasons. If treatment fails, other procedures (including root canal retreatment and/or oral surgery) may be necessary to attempt to retain the tooth, or it may require extraction.

I understand that I will be given a local anesthetic injection and that in rare situations, patients may have an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment, and that my jaw may be stiff and sore from the anesthetic injection or from holding my mouth open during treatment.

I understand that once root canal treatment is completed, I must promptly return to begin the next step in treatment. If I fail to return to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth.

Acknowledgement

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including diagnostic imaging.

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Patient Initial

Discussion & Consent for Root Canal Treatment (page 3)
Acknowledgement (continued)

I realize that in spite of the possible complications and risks, my recommended root canal therapy is necessary. I am aware that the practice of dentistry and surgery is not an exact science and 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 Dr. Beverly Jaiswal 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 risk of refusing treatment.

I understand that the treatment can also be performed by an endodontist (specialist) . I understand the risks and elect to have the procedure performed by Dr. Beverly Jaiswal. I understand that if any unexpected difficulties occur during treatment, I may be referred to an endodontist for further care.

_____	_____	_____
Patient or Guardian Signature	***Date***	***Time***
_____	_____	_____
Treating Dentist Signature	***Date***	***Time***
_____	_____	_____
Witness Signature	***Date***	***Time***