Southern Smiles
FAMILY & COSMETIC DENTISTRY
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Consent for Root Canal Therapy

Patient:_____ Date:_____ Tooth#:_____

It has been explained to me that there are certain inherent potential risks in any treatment or procedure, (including the administration of any necessary local anesthesia) which includes, but are not limited to:

A. Postoperative discomfort and swelling that may persist for several days.
B. Stretching of the corners of the mouth with resulting cracking and bruising.
C. Injury to the nerve underlying the teeth resulting in numbness at tingling or the lips, chin, gums, check, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
D. Re-infection of the canal and / or surrounding supporting tissue requiring re-treatment.
E. Inability to reach and treat the end of the root.
F. Abscess or cyst formation.
G. Perforation of the side of the root.
H. Calcification or closure of the canal.
I. Fracture of the root.
J. Discoloration of the tooth.
K. Broken file lodged in the canal.
L. Other_____.

It has been explained to me that root canal treatment is; Removal of the infected pulp cleaning of the canal and sealing the canal to prevent infection.
I understand that unless both steps are completed, the tooth can become re-infected which can lead to general health complications and the loss of the tooth. Therefore, it is essential that I complete root canal once the treatment is initiated in a timely manner (usually one to four weeks).

No guarantee or assurance has been given to me that the proposed treatment will be curative and /or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

Because successful treatment often depends upon compliance with the doctor's instructions, I agree to cooperate completely with the recommendations of the doctor and /or her assistants while I am under his care, realizing that any lack could result in a less than optimum result.

I understand that if I do not complete the root canal, I remain responsible for the full charge of the procedure.

I understand that frequently a root canal treated tooth will need to be restored with a full crown at a separate cost.
I certify that I have had an opportunity to read and fully understand the terms and words within the above and consent to the procedure (s). I also state that I read and write in English.

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____