**Informed consent for endodontic treatment**

**I consent to the necessary diagnostic procedures/testing and radiographs needed to determine if endodontic or root canal therapy is indicated for me.**

**I understand that other treatment options might be possible, such as:**

a) No treatment

b) Waiting for more definitive development of symptoms

c) Tooth extraction

**If endodontic treatment is advised I voluntarily give consent for treatment.**

I understand that the goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate (over 90%), it is a dental-biological procedure, and as with all medical and dental procedures it’s results cannot be guaranteed. Other factors such as a history of trauma or a long standing infection can negatively affect the prognosis. This procedure will not prevent future tooth decay, tooth fracture, or gum disease. Occasionally a tooth that has had root canal treatment may require retreatment, root surgery, or extraction. I am aware that the condition of the tooth may worsen and other systemic (medical) problems could develop if the recommended procedure is not done.

**Risks: are unlikely but may occur. They may include but are not limited to:**

a) Post-operative infection or pain, which may require additional treatment and/or the use of antibiotics or other medications.

b) Incomplete healing, which may require re-treatment and/or root canal surgery or extraction

c) Tooth and/or root fracture that may require additional treatment or extraction

d) Temporary or permanent numbness of the soft tissues of the lips and/or mouth

e) Perforation ( extra openings) of the root with instruments

f) Instrument breakage in the tooth which may require additional treatment or extraction

g) Blocked canals that cannot be ideally treated

h) Reactions to anesthetics, chemicals, or medications

i) Change in the bite or jaw joint soreness

j) Fracture, chipping, or loosening of the existing tooth or crown

**After completion of the root canal procedure, a temporary filling will be placed. I must return to my general dentist for the permanent restoration (filling and/or crown) to be determined by my general dentist. Failure to have the tooth properly restored in a timely manner (4-6 weeks) significantly increases the possibility of re-infection and failure of the root canal procedure and/ or fracture of the tooth.**

Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_