

ROOT CANAL TREATMENT AND INFORMED CONSENT

I have been **educated and informed** regarding the root canal treatment for which I **am giving my consent** and I understand the risks that are involved in performing this procedure. Specifically, I have been informed that:

1. There is about a five percent chance that my root canal therapy may not work. If the root canal fails, I may need additional treatment or the tooth may need to be removed. The fee charged for this root canal does not cover any additional treatment.
2. Any of the root canal instruments may break inside my tooth.
3. An instrument may create a whole, called a perforation, through the crown or root of the tooth.
4. A crown, bridge, veneer (cosmetic cover), natural crown, a dental restoration or my natural tooth may break or crack because of the root canal treatment.
5. The dentist may encounter complications which may include but are not limited to:
 - blocked canals -natural calcifications (hardening) -badly curved canals
 - split roots or fractured canals -periodontal damage or infection
 - broken instruments from a previous dentists' treatment or with our dentist
 - temporary or permanent nerve damage (lip may remain numb even after the procedure)

Complications may make it impossible to complete the root canal. If this is the case, I realize that there will be a fee for the time spent attempting the root canal.

6. I have the option of **refusing treatment** or of removing this tooth.
7. Any of the complications and problems may require me to have an additional treatment or surgery.
8. Teeth which require further treatment or re-treatment have a lower rate of success.
9. A tooth with a root canal should have a permanent crown and I promise to return for this needed dental work.
10. I have been informed about the medications that the dentist has prescribed to me and of their possible complications. I will follow the dentist's directions.
11. I agree to **return promptly** to have my root canal completed. I realize that if I fail to show up, or if I cancel future appointments and do not return, that I am still **responsible for the full fee** of the procedure.
12. If I fail to show up for a scheduled appointment, I take **full responsibility** for any serious consequences, such as hospitalization or death from infection, and hold the dentist harmless for my own acts.

I have had all my questions answered regarding this procedure and its potential risks to me. I understand this consent form and the staff have answered all of my questions related to this procedure. I give permission to the dentist to do this procedure.

Parent (Or Guardian) Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____