

**For Informational Use Only**

**INFORMED CONSENT FOR ENDODONTIC TREATMENT  
(Root Canals)**

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give my permission to \_\_\_\_\_ and his staff to perform the following endodontic (root canal) therapy:

TREATMENT PROPOSED: \_\_\_\_\_  
\_\_\_\_\_

I understand that endodontic (root canal) therapy is not an exact scientific procedure and that no guarantees can be made for a successful outcome. I acknowledge that no guarantees or assurances have been made to me concerning the results of the root canal therapy and its outcome. \_\_\_\_\_ and his staff have explained to me alternative methods of treatment, such as extraction or no treatment at all or antibiotic treatment and I agree to the above endodontic treatment proposal.

I understand that during the endodontic procedure, certain risks are inherent in this technique. Such risks include, but are not limited to, broken instruments in the canals of the tooth, perforation of the side of the tooth requiring corrective surgical procedures, perforation of the apex (top) of the tooth with a file instrument that may require corrective surgical procedures, perforation into the sinus cavities on root canals performed on upper teeth requiring corrective surgical procedures, the presence of calcification or highly irregular shapes and accessory canals in the tooth which potentially limit the chance of success as well as the possibility of a numbness (usually partial – sometimes permanent) on root canals performed on lower teeth that may require subsequent corrective surgical intervention.

I have been advised of the possibility of recurring infection, in spite of the root canal therapy and of the need for additional treatment such as an apicoectomy (which is a surgical procedure to eliminate reoccurring infection or to remove overfill material or perforated instruments) as well as additional surgical procedures to eliminate reoccurring infections that may not be controlled by the procedure and/or by antibiotics. Extraction of the tooth may become necessary in spite of the best endodontic techniques.

I am fully aware that a tooth treated with endodontic (root canal) therapy will become a brittle tooth and the tooth itself will become quite vulnerable to fracture in the future. This is so even if the root canal therapy is successful.

I have been advised in most cases that a full crown is recommended to be placed over the tooth to enhance its strength once the therapy is determined to have been successful. I have also been advised that oftentimes a post may be used to reinforce the strength of the tooth and the crown.

I have been given the opportunity to ask questions and have been given satisfactory answers to those questions. Knowing these risks and having my questions fully answered, I consent to the endodontic (root canal) treatment recommended. I acknowledge that I must notify \_\_\_\_\_ or his staff of any continuing pain, discomfort, drainage or numbness in the area that may occur after treatment sessions. I acknowledge that any medications that are prescribed for me must be taken as directed by \_\_\_\_\_.

\_\_\_\_\_  
(Signature of Patient, Patient's Guardian or Parent's Authorized Representative) Date: \_\_\_\_\_

\_\_\_\_\_  
(Witness) Date: \_\_\_\_\_