INFORMED CONSENT FOR ENDODONTIC (ROOT CANAL) THERAPY

Endodontic treatment involves the administration of local anesthetic, placement of a rubber barrier over the tooth, creating an opening in the biting surface of the tooth, and removing the diseased nerve in the middle of each root. A root canal filling is placed in the root and then, usually in your general dentist’s office, the tooth is permanently repaired with a new filling or a crown. I understand that there are alternatives to endodontic (root canal) therapy. They include, but are not limited to:

1) **No treatment.** My condition will probably worsen with time and may include pain, dangerous infection, loss of tooth.
2) **Extraction with nothing to fill the space.** This may result in a change in the bite, loss of function, gum disease.
3) **Extraction followed by a bridge, partial denture, or implant to fill the space.**
4) In the case of Re-treatment (of previously unsuccessful endodontic therapy), **Endodontic Surgery** may also be an option initially or required if re-treatment is unsuccessful.

I understand that there are certain potential risks and complications in any treatment and they include, but are not limited to:

1) Postoperative discomfort lasting a few hours to several days, usually related to how sore the tooth was before treatment.
2) Postoperative swelling or infection, usually related to the severity of the swelling/infection before treatment.
3) Failure rate of 5-10% under optimal conditions. If failure occurs, additional treatment will be required such as: re-treatment, endodontic surgery, or extraction of the tooth. Re-treatment failure rates are higher, but vary due to the suspected reason for the failure.
4) With some teeth, conventional endodontic (root canal) therapy may not be sufficient and additional treatment may be required in instances such as:
   a) If the canals are severely curved, blocked, or split such that they cannot be treated
   b) If an instrument separates (breaks) in the tooth during treatment
   c) Periodontal (Gum) disease is present or a problem for which periodontal treatment may be needed
   d) Pre-existing fractures, severe infections or cysts, or perforations of the root, tooth, or sinus.
5) **Restoration Damage** such as Porcelain Fracture while preparing the opening in the restoration (filling or crown). If damage occurs, often it can be repaired or re-cemented while in other cases it may require replacement.
6) Premature loss of the tooth due to progressive periodontal (gum) disease and/or loosening of the tooth.
7) Complications resulting from the use of instruments, materials, medications, anesthetics, and injections.

I understand the after endodontic therapy, my tooth may require an additional restoration (filling and/or crown). I understand that if I neglect to return to my comprehensive (family) dentist for the proper restoration within a few weeks (the recommended time will be discussed after your treatment here) there is an increased risk of: 1) failure of the root canal treatment, 2) infection, 3) fracture of the tooth and/or, 4) premature loss of the tooth. I understand that I may be asked to return to this office periodically to evaluate for continued healing.

No guarantee of success or perfect result has been given to me. Failure may result despite treatment and may require additional treatment and/or extraction of the tooth. Either Dr. Randall, Dr. Kim or Dr. Francisco has explained to me the diagnosis, method and manner of the proposed procedure(s), the risks of treatment or no treatment, prognosis (future outlook), and feasible alternatives. I fully understand this consent form and it does not encompass the entire discussion regarding the proposed treatment I had with the doctor.

Sign here, only if all of your questions have been answered to your satisfaction.

Patient (or legal guardian)______________________________________________________   Date______________________

Discussion Notes:

Doctor Signature________________________________________   Witness Signature (if applicable)_____________________
