DURANGO FAMILY DENTISTRY

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INFORMED CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Patient's Name: _____

Procedure: Root canal therapy on tooth/teeth number(s): _____

Location Description: _____

Alternatives to Procedure:

- No treatment;
- Extraction.

Possible Complications which have been discussed with me, include but are not limited to:

- Separation of instruments which may prevent successful treatment;
- Perforations (openings) of the crown or root of the tooth;
- Identification of crown or root fracture during or after treatment;
- Damage to existing crowns, bridges or other appliances;
- Root canal filling material which extends beyond the end or the root;
- Blocked root canals which may prevent successful treatment;
- Loss of tooth structure/weakening of tooth;
- Post-operative pain, swelling, and/or infection;
- 5-10% chance of failure.

To be read and signed by Responsible Party:

I, _____, understand that during treatment, complications may arise which make treatment more difficult or may require additional dental surgery. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever he deems advisable to correct the condition.

I understand that root canal treatment weakens the crown of the tooth. The dentist has explained to me the need for a restoration, which adequately protects the tooth, after root canal treatment has been completed. I understand that no guarantee of success has been or can be given. All of my questions have been answered by the dentist and I fully understand all the above statements contained in this consent form.

Signature: _____ Date: _____

Relationship to Patient: _____

Doctor's Signature: _____

Witness Signature: _____