CONSENT FOR NON-SURGICAL ENDODONTIC (ROOT CANAL)TREATMENT

Patient Name:_____ **Tooth**:_____

Purpose of Treatment

Recommendation for this treatment is based on visual examination(s), on x-rays and other diagnostic tests taken, and or Dr._____ knowledge of my medical and dental history. My needs and wants have also been taken into consideration.

A diagnosis of one or more teeth has been made indicating that there is infected, dead or dying nerve tissue within the tooth. Root canal treatment has been recommended in order to prevent the tooth from becoming a source of continued pain and/or infection. Root canal treatment involves cleaning out and disinfecting the inside nerve space of a tooth, enlargement of this space, and finally, filling the interior with a dense, non-irritating material. This space is filled so that no irritants remain within the tooth. Root canal treatment may take 1 or more visits to complete depending on the complexity of the tooth and/or infection.

Endodontic gum surgery may also be required when conventional root canal treatment will not or has not completely eliminated infection. This involves a small exposure of the tip of the root of the tooth and both removal of residual infection around the tip and the sealing off directly of the root tip.
After root canal treatment, there may be a temporary filling sealing the top of the tooth. I must have the tooth permanently restored or it may break.

Benefit of Treatment

The intended benefit of root canal treatment is to relieve my current symptoms and/or to permit me to continue with any additional treatment that my dentist has proposed. Root canal treatment also retains the tooth root in my mouth, permitting the tooth to be restored to proper function.
Loss of teeth can result in decreased ability to chew and to speak, as well as a change in appearance.

Alternatives to Treatment

Depending on the diagnosis, there may or may not be alternatives to root canal treatment that involve other types of dental care. The two most common alternatives to root canal treatment are:

- No treatment. I may choose to not have any treatment performed at all. If I choose no treatment, my condition may worse and I may risk serious personal injury, including severe pain, localized infection, loss of this tooth and possible other teeth, severe swelling and/or severe infection that may be potentially fatal.
- Extraction. The only alternative to root canal treatment that relieves pain and/or infection is removal of the entire tooth. The extracted tooth usually requires replacement by an artificial tooth by means of fixed bridge, dental implant or removable partial denture.

Without definitive root canal treatment, antibiotics will only help the body to control the size of the infection for a short time but will not cure an infected tooth.

Risks of Treatment

There are certain inherent and potential risks associated with root canal treatment. During and after treatment there may be pain or discomfort, swelling, bleeding, changes in the bite and loosening of dental restorations. It is possible for an infection to occur or an existing infection to worsen in the tooth being treated and/or in the area around the tooth. Antibiotics and/or other procedures may be needed to treat the infection.

Other risks include:

- Temporary jaw soreness from being open.
- Difficulty locating and working in all suspected canals.
- Incomplete fillings of all canals.
- Breakage of instruments within the root during treatments
- Unfavourable response of my body to some materials used during cleaning, disinfections, and filling of the root canals.
- Damage to existing fillings or crowns of the teeth being treated.

If any of the above occurs during treatment, Dr Miller/Dr. Goodman may continue with the knowledge that a lesser prognosis is expected, a referral to a root canal specialist for treatment may be recommended or the tooth may need to be extracted.

Prognosis

I have provided an accurate medical and personal history including antibiotics, drugs or other medications that I am currently taking as well as those to which I am allergic. I will also follow any and all treatment/ post treatment instructions as explained and directed to me. I permit the recommended diagnostic procedures, including x-rays, the chance of success of this root canal treatment is _____.

A return of the infection in the future may require treatment or endodontic surgery.

Acknowledgement

Dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I realize that in spite of the possible complications and risks, my recommended root canal treatment is necessary.

I have received information about the proposed treatment. I have discussed my treatment with Dr Miller/ Dr Goodman and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternative options and the risks of the recommended treatment.

_____ _____

Patient or Guardian Date

_____

Witness