Sample Form: Discussion and Consent for Root Canal (Endodontic) Treatment

Patient's Name:_____ Date of Birth:_____
Last *First* *Initial*

I am being provided with this information and consent form so that I may better understand the treatment recommended for me. Before making a treatment decision, I wish to be provided with sufficient information, in a way I can understand, in order to make a well informed decision regarding my proposed treatment.

I understand that I may **ask any questions I wish,** and that it is better to ask questions prior to treatment than to wonder about it after treatment has started.

Nature of Endodontic Treatment

Root canal treatment has been recommended for me on the following tooth (teeth):_____.

Root canal treatment (also called **endodontic** treatment) requires removing the nerve and other tissues (called the **pulp**) from inside the tooth and its root(s). It is done by first making an opening through the chewing surface of the tooth to gain access to the tooth's pulp. The contents of the canals are removed and the canals cleaned and shaped. The canals are then filled and sealed with an inert material. Following root canal treatment, the tooth will need a final restoration, usually a crown, to return it to proper function. The final restoration is not part of this discussion and consent.

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wishes also have been taken into consideration. Root canal treatment is necessary because of:

☐ Pain ☐ Infection ☐ Decay ☐ Broken Tooth/Teeth ☐ Other:_____

The intended benefit of root canal treatment is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed. Root canal treatment also retains the tooth root in my mouth, permitting the tooth to be restored to proper function.

The prognosis, or likelihood of success, of this root canal treatment is _____.

My root canal treatment is estimated to cost $_____ and is estimated to take _____ visit(s) to complete.

Alternatives to Endodontic Treatment

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

- **Extraction.** I may decide to have tooth #_____ removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- **No treatment.** I may decide not to have any treatment performed at all. If I refuse the recommended treatment, my condition may worsen and I may risk serious personal injury, including severe pain; localized infection; loss of this tooth and possibly other teeth; severe swelling; and/or severe infection that may be potentially fatal.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____.
Patient's Initials

continued…

Risks of Endodontic Treatment

I have been informed and fully understand that there are certain inherent and potential risks associated with root canal treatment. I understand that during and after treatment, I may experience pain or discomfort, swelling, bleeding, changes in my bite, and loosening or loss of dental restorations. I understand that 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, and that I may need antibiotics and/or other procedures to treat the infection.

I understand that root canal instruments sometimes separate (break) inside the canal. This separation is more likely when canals are curved and/or narrowed. If the separated fragment cannot be retrieved, it may require sealing inside the root canal. It also may be necessary to have oral surgery performed on the tooth root (apicoectomy) to address the problem. I understand that a separated instrument often decreases the likelihood of clinical success.

I understand that other risks include: perforation of the tooth or tooth root by an instrument; injury to soft tissues adjacent to the tooth; sinus perforation; and nerve disturbances such as temporary or permanent pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance, if ever. Some of the factors include but are not limited to: my resistance to infection; the specific bacteria causing the infection; the size, shape, and location of the canals; the force with which I bite. I understand that my case may be more difficult if my tooth has blocked canals, curved canals, or very narrow canals.

I understand that root canal treatment may not relieve my symptoms, that treatment can fail during or after completion of treatment; and that it may fail for unknown reasons. If treatment fails, other procedures (including root canal retreatment and/or oral surgery) may be necessary to attempt to retain the tooth, or it may require extraction.

I understand that I may be given a topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact Dr. _____ if numbness remains more than a few hours or if you develop a rash. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that once root canal treatment is completed, I must promptly return to begin the next step in treatment. If I fail to return to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth. Since tooth structure must be removed to complete the root canal procedure, I understand that my tooth may be more prone to fracture than would a sound tooth, even after a crown or other dental restoration is completed.

Other foreseeable risks not stated above include:_____

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including

Patient's Initials

continued…

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including medications I am currently taking (antibiotics, pain drugs, or other medications, including non-prescription medicines, herbs or supplements) and materials or medicines to which I am allergic. I will follow any and all treatment and post-treatment instructions as directed and explained to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended root canal treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the treatment.

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

I wish to proceed with the recommended treatment.

_____ *Patient's Initials*

I understand this treatment can also be performed by an endodontist (a root canal specialist).
I understand the risks and elect to have this procedure performed by Dr. _____.
I understand that if any unexpected difficulties occur during treatment, I may be referred to an endodontist for further care.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist

Signed:_____ Date:_____
Witness