



P.O. Box 576 • Eagle, CO 81631 • (970) 328-1116

Consent for Endodontic Therapy

Patient Name _____ Date _____

1. I hereby give consent for Dr. _____ perform the root canal treatment on tooth/teeth # _____
2. I understand that root canal treatment can have a very high degree of clinical success; however, as with any branch of medicine or dentistry, no guarantee of successful treatment can be given or implied. Occasionally, a tooth which has had root canal therapy may require retreatment, a surgical procedure, or even extraction. Root canal cases started in other offices or retreatment cases may have a lower success rate even when the procedure is carried out under optimal conditions.
3. I understand that to accomplish the root canal procedure, it is necessary to alter the existing tooth structure and/or restorations. These alterations require the placement of a **new restoration or crown following endodontic therapy**. I also understand that proper restoration of the tooth after root canal treatment is a necessity. A crown is generally recommended following the root canal treatment to protect the tooth from fracturing. The fee for endodontic treatment does not include these restorative procedures. In addition, I understand it is the patient's responsibility to have an appropriate restoration placed following the root canal procedure.
4. I understand that periodic recall examination of the tooth to include **radiographs is recommended to evaluate the success of the treatment rendered**. Compliance is the patient's responsibility.
5. Treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and placement of a rubber dam. In addition, a number of radiographs will be required will vary with the complexity of the case.
6. Possible **complications** of treatment include, but are not limited to:
 - a. curved canal/roots
 - b. calcifications in the root canal space
 - c. perforation of the crown or root canal
 - d. Fractures of the crown or root
 - e. infection, swelling, discoloration of the adjacent tissues
 - f. and pain during or following the treatment are also possible.
7. I understand that I am free to withdraw my consent and discontinue treatment at anytime; however, complications such as bone destruction, pain, infection and swelling may predictably occur if the root canal treatment is not completed.
8. The **number of treatment visits** required to complete the root canal **varies** with the complexity of each case.
9. I certify that I fully understood this consent for root canal therapy.

If you have any questions, please ask the doctor.

Signature _____ Date _____