DUODENT
BIELANY

ENDODONTIC (ROOT CANAL) TREATMENT
CONSENT FORM

Patient's Name

_____.

I have been advised by my doctor that I require endodontic treatment on tooth/teeth _____. I understand that there are alternatives to endodontic therapy including extraction and replacement of the lost tooth/teeth by a partial or complete denture, a bridge or a dental implant. I understand that the consequences of doing nothing will lead to worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease and infection problems. I am aware that endodontic treatment results in permanent mortification of the tooth and understand that it's necessary for the therapy.

Root canals generally have a high success rate. However many factors influence the healing of a tooth after treatment. These include general health, adequate gum attachment and bone support, shape and condition of the roots and nerve canal, previous dental care and pre-existing root fracture. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure. I understand that root canal treatment may not relieve my symptoms and treatment can sometimes fail for unexplained reasons. If treatment fails, other procedures (including re-treatment or surgery) may be necessary to retain the tooth, or it may have to be extracted.

In some cases, endodontic therapy can be complicated by anatomy of the root/nerve system. This can include curved or calcified (blocked) canals and small accessory canals that may be difficult to instrument. The instruments used by my dentist are state of the art nickel titanium and are able to overcome MOST of these anatomical problems. However, in some cases, an instrument may separate in a canal.

Some complications of root canal therapy may be, but are not limited to:

- Failure of the procedure necessitating re-treatment, root surgery, or extraction
- Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer
- Breakage of an instrument inside the canal during treatment, which may be left as is, or may require surgery for removal
- Perforation of the canal with instruments, which may require additional surgical treatment or result in the loss of the tooth.

I understand that local anesthetic will be given. Some discomfort following treatment may develop from the injection area and from opening my mouth during treatment. On rare occasions, only a partial return of nerve sensation may occur.

I consent to the taking of photographs and x-rays (before, during and after treatment) to assist in the planning and treatment (if required).

The estimated cost od root canal teratment is: _____

The above amount does not include the costs of reconstruction, which i san independent procedure.

Successful completion of the root canal procedure does not prevent future decay or fracture. An endodontically treated tooth will become more brittle and may discolor. I understand that once root canal treatment is completed, I must have a permanent restoration (filling / onlay / crown) placed by my dentist. If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture and/or loss of the tooth.

I am aware that after root canal teratment it is necessary to undergo periodic check-ups (including taking x-rays) in accordance with the dentist's recommendations. This is important to evaluate the healing proces of my treated tooth.

By providing my signature, I certify that I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives including the consequences of doing nothing. I have had a chance to have all of my questions answered.

_____ Date, Dentist's Signature

_____ Patient's Signature