

**INFORMATIONAL USE ONLY**

**ENDODONTIC (Root Canal Therapy)  
INFORMED CONSENT**

I hereby consent to the endodontic treatment procedure for myself (or my child \_\_\_\_\_) on tooth number(s) \_\_\_\_\_ to be performed by Dr. \_\_\_\_\_.

I understand the nature of the problem causing the need for treatment (that the nerve tissue within the tooth is dead or dying and causing acute or potential risk of infection in the bone surrounding the tooth), and I understand the reasons for treatment (removal of the nerve tissue to relieve or prevent infection). The alternative treatment of extraction of the tooth has been explained to me as well as the potential consequences if no treatment is performed. I also understand the possible risks of not completing this treatment once it is begun.

I understand that during or after endodontic treatment there is a possibility the following may occur: pain, swelling, infection, reinfection, cold sores, canker sores, irritation or injury to the oral tissues, periodontal involvement (bone loss and tooth mobility due to infection), calcified canals preventing complete endodontic therapy, allergic reactions to dental material or medications, breakage of instruments (such as files) within the root canal or perforation of the crown or root of the tooth (by dental instruments or as a pre-existing condition) which may require surgical correction or result in the loss of the tooth.

I understand that root canal therapy is not always successful (approximately 90-95% of cases are treated successfully) and that the endodontic procedure may have to be repeated and/or an additional surgical procedure may be required at additional expense. I understand that the treatment may involve several appointments to complete, and I may lose this tooth despite all efforts to save it.

I understand that after endodontic treatment, the tooth will be more brittle, may discolor (possibly requiring bleaching or veneering), and will require restorative treatment (filling, post, buildup, and/or crown), and I have been given an estimate of fees for the completion of this work. Failure to complete this restorative treatment may result in the loss of the tooth due to fracture. I have been given the opportunity to ask questions and have received satisfactory answers. I am aware that the practice of Dentistry and Endodontics is not an exact science, and I acknowledge that no guarantees have been made to me as a result of the procedure authorized above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or person with authority to consent for patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness