

**CONSENT FOR  
ENDODONTIC THERAPY**

Patient Name \_\_\_\_\_  
Tooth \_\_\_\_\_

*Please read and then initial each paragraph when you understand the contents.*

1. I hereby give my consent to \_\_\_\_\_  
to perform the root canal on the tooth or teeth listed:
2. I understand that root canal treatment is a procedure to retain a tooth, which may otherwise require extraction.
3. I understand that root canal treatment can have a high degree of clinical success (85-95% of the routine cases are successful), 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 treatment, 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.
4. 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 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.
5. I understand the 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.
6. 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 necessary to accomplish the root canal procedure. The number of radiographs required will vary with the complexity of the case.
7. Possible complications of treatment include, but are not limited to:
  - a. Curved canals/roots
  - b. Calcifications in the root canal space
  - c. Procedural difficulties such as the separation of instruments in the root canal space, and perforation of the crown or root while looking for the root canal space
  - d. Fracture on the crown or root
  - e. Infection, swelling or discoloration of the adjacent tissues
  - f. Pain during or following treatment
  - g. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed
8. I understand that I am free to withdraw my consent and discontinue treatment at any time; however complications such as bone destruction, infection and swelling, and/or pain, etc., may predictably occur if the root canal treatment is not completed.
9. The number of treatment visits required to complete the root canal varies with the complexity of each case. Generally, the routine cases can be completed in two or three appointments.
10. If at any time I have any questions about the treatment I am receiving, they will be promptly answered.

**SIGNATURES**

SIGNATURES OF PATIENT OR LEGAL DESIGNEE

DATE

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF WITNESS

DATE

\_\_\_\_\_

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