Discussion and Informed Consent for Root Canal Treatment

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment & Tooth Number(s): _____

Facts for Consideration

Patient's initials required

_____ Root canal treatment, also called *endodontic treatment,* involves removing the nerve tissue (called *pulp*) located in the center of the tooth and its root or roots (called the *root canal*). Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp, which are then removed. Medications may be used to disinfect the interior of the tooth to prevent further infection. Root canal treatment may relieve symptoms such as pain and discomfort. If any unexpected difficulties occur during treatment, a general dentist may refer you to an endodontist, who is a specialist in root canal treatment.

_____ Twisted, curved, accessory or blocked canal(s) may prevent removal of all of the inflamed or infected pulp. The presence of any residual pulp in the canal(s) may cause your symptoms to continue or worsen. This might require an additional procedure called an *apicoectomy*. A small opening is cut in the gums and surrounding bone; any infected tissue is removed and the canal(s) is sealed. An apicoectomy may also be required if your symptoms continue and the tooth does not heal.

_____ Each empty tooth canal(s) that can be located is filled with a material designed specifically for root canal therapy. Sometimes a canal is present but cannot be located. Occasionally, a post is also inserted into the canal to help secure restorations of the tooth. After filling through the opening in the tooth, the tooth is closed with a temporary filling. At a later appointment, a permanent filling or *crown* may be placed. This is a separate dental procedure not included in this discussion.

_____ Once the root canal treatment is completed, it is essential to return promptly to begin the next step in treatment. Because a temporary seal is designed to last only a short time, failing to return as directed to have the tooth sealed permanently with a crown or filling can lead to other problems, such as the need to repeat the treatment at an additional cost and deterioration of the seal, resulting in decay, infection, gum disease, fracture and the possible loss of the tooth. Failure to restore a root canal treated tooth may result in fracture and loss of the tooth

_____ Even in cases with no complications where a crown or filling is placed right away, this procedure will not prevent future tooth decay, tooth fracture or gum disease and occasionally a tooth that has had root canal treatment may require endodontic retreatment (repeat), endodontic surgery or tooth extraction.

Benefits of Root Canal Treatment, Not Limited to the Following:

_____ Root canal treatment is intended to extend the lifespan of your tooth, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment may also be recommended to relieve the symptoms that may be associated with the diagnosis described above.

Risks of Root Canal Treatment, Not Limited to the Following:

_____ I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible infection may accompany root canal treatment and may require treatment with antibiotics. I will immediately contact the office or my dentist if my conditions worsen or if I experience fever, chills, sweats, numbness, sinus problems, severe pain or swelling.

_____ I understand that I may receive a local anesthetic (numbing agent) by injection and/or other medication. In rare instances, patients may have a reaction to the anesthetic such that it reduces one's ability to control swallowing, which may require emergency medical attention. This increases the chance of swallowing foreign objects during treatment. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury to the face or oral cavity can result from an injection of local anesthesia resulting in numbness of the lip, chin, gums, teeth and cheek and possibly loss of the sense of taste.

_____ I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications and supplements I am currently taking, which are: _____

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____ I understand that occasionally a root canal instrument may separate in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment may be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, nontoxic surgical stainless steel and typically cause no harm). It may also be necessary to perform an apicoectomy as described above to seal the end or lower part of the root canal.

_____ I understand that during treatment the root canal filling material may extrude out the root canal into the surrounding bone and tissue. Occasionally, an apicoectomy may be necessary for retrieving the filling material and sealing the root canal.

_____ I understand that other complications which may occur include, but are not limited to, perforations (extra openings) of the canal made by an instrument, perforation of the sinus cavity, blocked root canals that cannot be completely cleaned and filled, fracture, chipping or loosening of existing adjacent tooth or crown requiring replacement at an additional cost and temporary or permanent numbness or painful nerve sensations.

_____ I understand teeth that have received root canal treatments may become brittle and be more prone to cracking and breaking over time, particularly if the crown is not restored with a large filling or artificial crown, which may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal treatment may not relieve all symptoms. The presence of gum disease (*periodontal disease*) can increase the chance of losing a tooth even though root canal treatment was successful.

_____ There is no guarantee of success. I understand that root canal treatment may not relieve my symptoms,and I may need my tooth extracted.

Consequences if No Root Canal Treatment Is Administered, Not Limited to the Following:

_____ I understand that if I do not have root canal treatment, my discomfort may continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually the loss of my tooth and/or adjacent teeth.

Alternative Treatments if Root Canal Treatment Is Not the Only Solution, Not Limited to the Following:

_____ I understand that depending on my diagnosis, alternatives to root canal treatment may exist that involve other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an *implant.* I have asked my dentist about the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures, its risks, benefits, alternatives and cost.

Alternatives discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Check the boxes below that apply to you:

Consent

☐ I have been informed both verbally and by the information provided on this form of the risks and benefits of the proposed treatment.

☐ I have been informed both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with . (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date