CONSENT FOR ROOT CANAL TREATMENT

I hereby authorize the dentist to perform a root canal on

The dentist has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. I understand that the most common alternatives to root canal treatment are extraction or no treatment. I may choose to have this tooth removed which may require replacement with an artificial tooth by means of a fixed bridge, dental implant or removable partial denture. I may choose to have no treatment done, in which case the condition may worsen and I risk serious injury including severe pain & /or swelling.

I have been offered the option of having the root treatment done by a specialist with a higher chance of success than with a general dentist. I am aware that specialist treatment will incur private fees.

The dentist has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatments, and the dentist has explained the risks and benefits of the alternatives. I also understand that although root canal therapy has a good success rate, the dentist has not guaranteed or warranted a perfect result. The dentist has explained to me that there are certain potential risks in the procedure. These Include but are not limited to:

1. Inability to completely fill the root because the canal is calcified or has a unique curvature (This may require endodontic surgery or extraction of the tooth)
2. Infection that may occur and may continue, requiring further endodontic surgery or extraction.
3. Fracture or breakage of the root or crown portion during or after treatment.
4. Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved
5. Perforation of the tooth during treatment
6. Damage to existing fillings, crowns or porcelain veneers
7. Altered sensitivity after treatment
8. Allergic reaction to materials used

Unforeseen conditions may arise that require a procedure that is different than set forth above or a referral to a specialist. I authorize the dentist to perform such procedure when, in their professional judgment, the procedures are necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medication.

PATIENTS SIGNTURE