tuscany dental centre

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# ***Consent for Root Canal Treatment***

Patient Name: _____

I hereby authorize Dr _____and any associates to perform a root canal on tooth / teeth number (s): _____

The doctor has explained to me that the purpose of this procedure is to retain the tooth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand the risks and benefits of the alternatives. I also understand that root canal therapy has a high success rate, but that there are no guarantees. It has been explained to me that there are certain potential risks and these include:

- Inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth)
- Instrument separation in the canal
- Infection that may occur and may continue, requiring further endodontic surgery or extraction
- Tooth and/or root fracture that may require extraction
- Post-treatment discomfort
- Temporary or permanent numbness
- Change in the bite or jaw joint difficulty (TMJ problems or TMD)
- Damage to existing fillings, crowns or porcelain veneers
- As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues

I have had an opportunity to ask questions with my doctor and I consent to the procedure.

_____ _____

Patient / guardian signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship