Informed Consent for Endodontic Treatment: Root Canal Therapy by the McCarl Dental Group

I ________________________________ hereby authorize ___________________________ to perform endodontic treatment (Root Canal Therapy) as needed for my dental problem or condition. I authorize the use of medications, anesthetics, and any diagnostic procedures deemed reasonable and necessary, understanding that certain risks are involved.

Possible risks of endodontic treatment include, but are not limited to: Swelling, pain, bruising, breakage of instruments, fractured roots, calcified canals, residual numbness, perforation of the root or sinus, allergic reaction to medications, residual infection and/or loss of teeth.

Treatment alternatives have been explained to me, including but not limited to: extraction (with or without replacement), and/or referral to an endodontic specialist. I also understand declining treatment may result in serious consequences, such as, increased pain, swelling, infection, fever, loss of bone, and tooth loss.

Treatment will be performed within accepted methods of clinical practice, including the use of x-rays, as needed.

Following endodontic treatment, there is a higher risk of tooth fracture, and it is extremely important for the tooth to be restored with a crown, or suitable filling, to avoid possible fracture, re-infection, and/or loss of the tooth.

I understand that even with endodontic treatment, approximately 10% of root canal treated teeth require further treatment or extraction.

I understand my risks, treatment options, and fees for this endodontic treatment. I have had the opportunity to ask questions and had them answered in a satisfactory manner.

Patient Signature:____Date:___________

Dr. Signature:____Date:__________