**Consent for Root Canal Treatment**

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective(choice rather than urgency) procedure and that there are alternative treatments, and the doctor has explained the risks, problems and benefits of the alternatives. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result. The doctor has explained to me that there are certain potential risks in the procedure.

These include:

1. **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)

 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 or root** of the tooth during treatment

 6. **Damage to existing fillings, crowns or porcelain veneers**

 7. As a result of the injection or use of anaesthesia, 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**.

8. Sometimes, root may be ending in nerve canal causing **nerve related problems.**

9. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain).

These risks, complications or side effects are minimal and mostly manageable, cost of which is not covered. The complications are rare. The list of complication is exhaustive, not to frighten you but necessary for informed consent.

**Termination of treatment**: It is understood that treatment can be terminated for failure to cooperate, missing appointments, not wearing appliances, excessive breakage, failure to keep financial commitments, relocation, personal conflicts or for any other reason the doctor feels necessary. If termination is necessary, the patient will be given ample time to locate another orthodontist to continue treatment or the braces will be removed.

**Expectations**: All patients can expect improvement with their particular problem, but, in many cases, absolute perfection is impossible.

I understand that the medications, drugs, anaesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anaesthetics 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 medications. Please do not hesitate to ask the doctor or the staff if you have any questions.

Patient’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_