CONSENT FOR ENDODONTIC TREATMENT

Name_____ Date _____

Procedure(s)_____

We are concerned not only about your dental health and endodontic treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our commitment to you is to provide you with detailed and complete information about your dental needs as we diagnose them. We will share our diagnostic processes with you, and we invite and welcome all of your questions regarding our treatment.

It has explained to me that there are certain inherent and potential risks associated with the above mentioned treatment, procedure or sedation. The risks include yet are not limited to.

Towards this aim of a mutual sharing of information, we feel it is important to advise you of the reasonably foreseeable risks of endodontic therapy. The following is important information you should consider to aid your treatment decision.

- Root canal therapy is a procedure designed to retain a tooth that may otherwise require extraction. Root canal therapy has a very high degree of success. However, it is a biological procedure, and results cannot therefore be guaranteed.
- Approximately 5% to 10% of teeth that have undergone non-surgical root canal therapy may require retreatment or root-end surgery.
- Despite our best efforts, approximately 5%. of endodontically treated teeth may fail and require extraction.
- Final restoration (crown) of the tooth that has undergone root canal therapy is essential to root canal success and retention of the tooth. A final restoration should be completed within 30 days of root canal therapy.

I have read this consent and have been offered a full explanation of its contents.
I understand this document and hereby give my informed consent for dental treatment.

_____ _____
Patient/Parent/ or Guardian signature Date

_____ _____
Doctor's signature Signature of witness

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