Dentists Choice

Informed Consent
Root Canal Treatment

Date:

Patient:

Date of Birth:

Endodontic therapy, commonly referred to as root canal treatment, is a dental procedure designed to treat infection or damage within the pulp of the tooth. **This document aims to provide essential information regarding the procedure, associated risks, benefits, and available alternatives, thereby allowing you to make an informed decision about your treatment.**

The primary objective of root canal treatment is to remove infected or damaged pulp tissue, alleviate discomfort, and preserve the tooth rather than removing it.

Indications for Rooth Canal Treatment:

- Advanced tooth decay.
- Infection or abscess within the tooth.
- Trauma or injury affecting the tooth.
- Cracked or fractured tooth.

Root canal treatment generally encompasses the following steps:

- Administration of local anesthesia to numb the area surrounding the affected tooth.
- Placement of a dental dam to isolate the tooth for patient protection.
- Creation of an access opening in the crown of the tooth to reach the pulp chamber.
- Removal of infected or damaged pulp tissue, followed by cleaning and shaping of the canals.
- Filling of the canals with gutta-percha, a rubber-like biocompatible material. In some cases, a different material is used as deemed necessary.
- Placement of a temporary or permanent filling to close access opening in the tooth.
- Possible placement of a crown to restore the tooth's function and appearance.

Prognosis: _____

While root canal treatment generally has a high degree of success, there are no guarantees or warranties.

Estimated Time/Visits: _____
Estimated Fees: _____

Possible risks and complications that may arise:

- Pain or discomfort during or after the procedure.
- Tongue, chin, gums, cheeks, and teeth, numbness may occur.
- Sinus problems or perforations.
- Reactions to local anesthetic injections.
- Jaw muscle cramps and spasm; temporomandibular joint difficulty especially if there is a pre-existing condition (TMD).
- Complications resulting from calcified canals, severe root curvature, inaccessible canals, or other anatomical variations.

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Possible risks and complications continued:

- Damage to crowns or bridges.
- Referred pain to ear, neck, and head.
- Delayed healing.
- Treatment failure, under or overfilling, file separation (Broken files), or root perforation.
- Complications resulting from the use of dental medications, anesthetics, and injections.
- Reactions to medications causing drowsiness and lack of coordination.
- Antibiotics may inhibit the effectiveness of birth control pills or may cause an antibiotic associated colitis.
- Infection.
- Damage to surrounding tissues.
- Incomplete removal of infected tissue, necessitating further treatment.
- Fracture or loss of the tooth.
- In some cases, surgery may be required.

Benefits of Root Canal Treatment:

Root canal treatment confers several significant benefits:

- Relief from pain and discomfort.
- Preservation of the natural tooth.
- Restoration of normal chewing and biting function.
- Prevention of further infection or abscess.

Alternatives to Root Canal Treatment:

- Tooth extraction:
  - Removal of the affected tooth, followed by replacement with a dental implant, bridge, or denture.
- No treatment and associated risks:
  - Infection.
  - Loss of tooth/teeth.
  - Possible systemic problems.

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Consent:

○ I understand that during the course of treatment, unforeseen conditions may arise and may necessitate further procedures and / or deviation from the initial treatment plan, therefore I consent to the performance of additional procedures that Dr. _____ consider necessary to complete the treatment plan for my benefit.

○ I understand that due to the nature of any dental treatment, there are no guarantees/warranties.

○ All of my questions have been answered to my satisfaction.

○ I understand my financial obligations, and that I am responsible for all fees regardless of insurance coverage, unless prior arrangements have been made.

○ I confirm that I have read and understand the above. I hereby consent to the proposed treatment plan.

Patient/Legal Guardian Name: _____
Patient/Legal Guardian Signature: _____
Doctor Name: _____
Doctor Signature: _____
Interpreter (if needed): _____
Witness: _____

Dentist Certification:

I certify that I have explained the above proposed treatment including risks, benefits, alternative treatment options, as well as the consequences of no treatment. I have answered all the patient's questions to her/his satisfaction and believe that the patient fully understands what I have explained.

Dentist: _____
Date: _____