

**CONSENT FOR ROOT CANAL TREATMENT**

I hereby authorize: Dr. Cristina Maresca to perform a root canal on tooth/teeth number(s): \_\_\_\_\_  
DX \_\_\_\_\_ Prognosis: \_\_\_\_\_

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, as with all medical and dental procedures, it is a procedure whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally an unapparent, undiagnosed or hidden problem arises. This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had root canal treatment may require re- treatment, endodontic surgery, or tooth extraction.

**Risks:** Are unlikely, but may occur. They might include but are not limited to:

- a. Instrument separation in the canal.
- b. Perforations (extra openings) of the canal with instruments.
- c. Blocked root canals that cannot be ideally completed.
- d. Incomplete healing.
- e. Post-operative infection requiring additional treatment or the use of antibiotics.
- f. Tooth and/or root fracture that may require extraction.
- g. Fracture, chipping, or loosening of existing tooth or crown.
- h. Post-treatment discomfort.
- i. Temporary or permanent numbness.
- j. Change in the bite or jaw joint difficulty (TMJ problems or TMD).
- k. Medical problems may occur if I do not have the root canal completed.
- l. Reactions to anesthetics, chemicals or medications. Including Sodium Hypochlorite Accidents.
- m. Temporary inflammation of the face.

**Prescribed medications** and drugs can cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs) it is not advisable to operate any vehicle or hazardous device until recovered from their effects.

**Other Treatment Choices:** These include: No treatment at all, waiting for more definitive development of symptoms and extraction: To be replaced with either: Nothing, a partial, a bridge or an implant.

**ACKNOWLEDGEMENT AND CONSENT:** I, the undersigned, being the patient (parent or guardian of the minor patient) acknowledge that I have read this form and consent to the performing of \_\_\_\_\_. I reserve the right to refuse treatment if after case of discussion with the doctor I do not want the recommended treatment. I also understand that after the completion of the root canal, I will need a **Permanent restoration** (filling, post, core and or crown). This is a separate procedure and I will be billed separately. Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture.

I have had an opportunity to ask questions of my treating doctor and I am satisfied with the answers that I have received. I consent to the procedure.

\_\_\_\_\_/201\_\_\_\_ (\_\_\_\_)\_\_\_\_\_  
Patient (parent or guardian if minor) **Signature** Date Phone Number

\_\_\_\_\_/201\_\_\_\_  
Patient (parent or guardian if minor) **Print Name here** Date

\_\_\_\_\_/201\_\_\_\_  
Witness Date