Root Canal Treatment Consent Form

I understand there is no guarantee that root canal therapy will save my tooth and that complications may arise from treatment. These include, but are not limited to: File separation (breakage of an instrument inside the tooth); Root/tooth perforation; Root fracture; Final fill extending past the root of the tooth; Recurrent infection; Pain; Swelling; Numbness (may be permanent). If a post needs to be placed, I understand there are risks involved including, but not limited to: Root perforation; Crown or Root fracture; Numbness (may be permanent); Loosening or Breakage of the post; Soreness; Sensitivity. I understand that I may need further treatment by a specialist and the costs incurred will be my responsibility.

By signing this form, I understand that analgesics and other medications, including local anesthetics, can cause allergic reactions resulting in redness, swelling, nausea, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that dentistry is not an exact science and therefore no guarantee or assurance has been made to me regarding the dental treatment I have authorized. I certify that I have read and fully understand the above authorization and informed consent I have had the opportunity to discuss and ask any questions regarding the dental treatment I will receive, and all questions have been answered to my satisfaction. I give my consent willingly to this procedure.

Patient Name

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Signature of patient, legal Guardian, or authorized representative

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Date _____