CARE DENTAL WINDSOR

Private & Confidential

CONSENT FOR ROOT CANAL TREATMENT

Patient Name: _____
Today's Date: _____ Tooth : _____

- I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance. This includes my resistance to infection, the bacteria causing the infection, the size, shape and location of the canals.

- I understand that root canal treatment has a very high success rate, but no guarantee can be given for a perfect result. Treatment may not relieve my symptoms and treatment can occasionally fail for unexplained reasons.

Risks of Root Canal Treatment

- Inability to completely fill the root canal.

- Fracture or breakage of the root or crown during or after treatment.

- Inadvertent separation of files or instruments within the root canal system that are unable to be retrieved.

- Perforation of the tooth during treatment.

- Damage to existing fillings, crowns or porcelain veneers.

- Infection may reoccur and continue, requiring further treatment or extraction.

- I understand that during and after treatment, I may experience some pain or discomfort, swelling, bleeding and limited mouth opening. I understand local anaesthesia will be given. I may also need antibiotics to treat any associated infections.

- I understand that once root canal treatment is completed, **I must have a permanent restoration placed within the next few weeks**. If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture and/or loss of the tooth.

Alternatives to Root Canal Treatment

The most common alternatives include:

- **Extraction** – Further treatment may be required including replacement by an artificial tooth by means of a removal denture, fixed bridge or dental implant.

- **No treatment** – If I choose no treatment, my condition may worsen and I risk personal injury, including severe pain, infection, swelling and loss of this tooth.

I acknowledge that I have provided an accurate medical history, will follow treatment recommendations and have had the opportunity to ask questions about these risks in continuing with root canal treatment.

Patient's Signature (Guardian if patient is a minor) : _____

Dentist's Signature : _____

PLEASE ADVISE US AS SOON AS POSSIBLE IF YOU DECIDE NOT TO RECEIVE ROOT CANAL TREATMENT