Endodontic Therapy Consent Form

Patient Name: _____

Date of Birth: _____

Treating Dentist: _____

Date: _____

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1. Description of the Procedure

I understand that endodontic therapy ("root canal treatment") involves the removal of infected or damaged tissue from inside the tooth. The canals will be cleaned, shaped, and filled with a biocompatible material to prevent further infection. X-rays and local anesthesia may be used to assist in providing successful treatment.

2. Risks and Complications

- Swelling, pain, or infection following the procedure
- Incomplete healing or need for additional treatment
- Instrument breakage in the canal or root perforation
- Tooth discoloration or loss of tooth
- Numbness and tingling due to anesthetic
- Possible referral for surgical or specialist care

3. Alternatives

I have been informed of alternatives to endodontic therapy, including:

- Extraction of the tooth
- No treatment (with risk of pain, swelling, or worsening infection)
- Referral to a specialist

4. Benefits

The potential benefits of root canal treatment include preservation of the natural tooth, relief from pain or discomfort, and removal of infection.

5. Patient Responsibilities

- Follow post-treatment instructions and care recommendations
- Schedule and attend all follow-up appointments
- Notify the dentist immediately if pain, swelling, or unusual symptoms occur
- Understand that a crown or other restoration may be recommended after root canal therapy

6. Informed Consent

I have had the opportunity to ask questions about the procedure, risks, benefits, and alternatives. My questions have been answered to my satisfaction. I understand the information provided and voluntarily consent to endodontic therapy.

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____