Great Neck Endodontics
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Informed Consent for Root Canal Treatment

I am aware that the recommended treatment for my condition is endodontic (root canal) treatment of tooth #(s) _____ in the opinion of my dentist. I am aware that the practice of dentistry is not an exact science, and even though very successful, no guarantees have been made to me concerning the results of the procedure.

I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease problem. Some complications of root canal treatment may be, but not limited to:

Failure of the procedure necessitating retreatment, root surgery, or extraction.

Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer.

Breaking of an instrument inside the canal during treatment, which may be left as is, or may require surgery for removal or root resection.

Perforation of the canal with instruments which may require additional surgical treatment or result in the loss of the tooth.

Damage to sinuses or nerves resulting in possible temporary or permanent numbness. It can also result in tingling of lips, chin, tongue or other areas.

Successful completion of the root canal procedure does not prevent future decay or fracture. A tooth that was treated with root canal therapy will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chances of fracture. I also understand that the necessary treatment of the involved tooth (teeth) is not completed until the final restoration has been placed by the restorative dentist. This final restoration should not be delayed as a delay can lead to coronal (bacterial) leakage worsening the long term prognosis of the endodontic treatment performed.

I understand the recommended treatment, the risk of such treatment, and alternatives and the risks of these alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me, and I have had a chance to have all of my questions answered.

Root canal therapy of tooth # _____.

Root Canal Retreatment of tooth # _____.

Printed name of patient X_____

Signature of Responsible Party X_____ Date X_____

Printed name of minor is applicable _____

Doctor's Signature _____ Date _____