

**INFORMED CONSENT  
ROOT CANAL THERAPY**

**I UNDERSTAND that ROOT CANAL THERAPY includes possible inherent risks such as, but not limited to the following:**

- 1. The tooth may remain tender or even quite painful for a period of time during and after completed treatment.** If pain is severe or swelling occurs, please call our office immediately.
- 2. In some teeth, regular root canal therapy alone may not be sufficient.** If the canals are blocked, excessively curved, inaccessible, inadvertent pulp chamber or root perforation, or if there is substantial infection in the bone around the tooth, additional oral surgery, including apicoectomy(s) or possibly extraction may become necessary.
- 3. Root canal treated teeth may become somewhat brittle and subject to cracking or fracturing.** Crowning (capping) the tooth is the best prevention to avoid this problem from occurring.
- 4. Root canal treated teeth must be protected.** During and after treatment, your tooth in most instances will have only a temporary filling. (should this come out, please call us for a replacement). It is advisable to crown (cap) the tooth as soon as possible.
- 5. Root canal therapy is not always successful.** Many factors influence success: adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; absence of trauma; pre-existing undetectable root fractures. No matter how successfully a tooth may appear to be treated, there is the possibility of failure and consequent extraction.
- 6. Root fracture is one of the main reasons why root canals fail.** Unfortunately, "hairline" cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, cracking of the tooth, large fillings, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment, usually necessitates extraction.
- 7. There are alternatives to root canal treatment.** These alternatives (though not of choice) include: no treatment; extraction; extraction followed by bridge placement or partial denture placement; and or extraction followed by implant and individual crown placement.
- 8. Because of the fragility and small diameter of root canal instruments used in root canal treatment, there is the possibility of instrument separation.** This may in some instances necessitate either root surgery or extraction of the tooth.
- 9. Medication.** Analgesics or antibiotics may be prescribed depending on symptoms and/or treatment findings. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that antibiotics cause these contraceptives to be ineffective. Other methods of contraception must be utilized during the treatment period.
- 10. ONCE TREATMENT IS BEGUN, it is absolutely necessary that the root canal treatment is completed. One or more appointments may be required to complete treatment. It is a patient's responsibility to seek attention should any undue circumstances occur; and the patient must diligently follow any and all preoperative and/or postoperative instructions given to them.**

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I have been given the option of seeking endodontic therapy with a specialist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Peterson and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

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Patient's name (please print)

\_\_\_\_\_  
Signature of patient, legal guardian    Date  
or authorized representative

\_\_\_\_\_  
Witness to signature

\_\_\_\_\_  
Date