12533, Kennedy Road, Caledon, L7C 2H1

ROOT CANAL TREATMENT INFORMED CONSENT

I hereby authorize Dr.__________________________________ of Kennedy North Dentistry to perform root canal treatment on tooth # _____.

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is **an elective procedure** and that there are alternative treatments, and the doctor has explained the risks and benefits of the alternatives. I also understand that root canal therapy has **a very high success rate**, but the doctor has not guaranteed or warranted a perfect result. The doctor has explained to me that there are certain potential risks in the procedure. These include:

1. **Inability to completely fill** the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth)
2. **Infection** that may occur and may continue, requiring further endodontic surgery or extraction
3. **Fracture or breakage** of the root or crown portion during or after treatment
4. **Inadvertent breakage of files or instruments** within the root canal system that are unable to be retrieved
5. **Perforation or hole** in the tooth or root of the tooth during treatment
6. **Damage** to existing fillings, crowns or porcelain veneers
7. As a result of the injection or use of **anesthesia**, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues.
8. Other:____

I have the option of refusing treatment or removing this tooth.
Unforeseen conditions may arise that require a procedure that is different than set forth above, **a repeat treatment**, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain).

I consent to the administration of such local anesthesia as is required for the said dental treatment. I also certify that no guarantee has been made to the results that may be obtained.

I agree to **return promptly** to have my root canal completed (if a pulp has had to be done first). I realize that if I fail to show up, or if I cancel future appointments and do not return, that I am still **responsible for the full fee** of the procedure once it has started. (if a pulp is done first there will be 2 charges)

If I fail to show up for a scheduled appointment, I take **full responsibility** for any serious consequences, such as hospitalization or death from infection and hold the dentist harmless for my own acts.

The necessary procedure is performed under local anesthetic with the patient fully aware.

I read and understand English – circle one Yes No

____________________	______________________	____________________
Signature	Print Name	Witness