Informed Consent: Endodontic Journey

I, [Patient's Name], entrust Dr. [Dentist's Name] and their proficient dental team to undertake endodontic therapy or any immediate alternative procedures necessary for the restoration of tooth #[to be filled by dentist].

I hereby authorize the utilization and application of local anesthetics, the capture of radiographs, and any immediate interventions deemed essential to execute the root canal procedure. I acknowledge and comprehend the benefits and potential drawbacks (i.e., risks) associated with the treatment to which I am consenting. I am aware that the current treatment plan might undergo modifications post the initiation of the root canal, which may include but are not limited to: pulpotomy, endodontic surgeries (apicoectomy), tooth extraction, or even opting for no further treatment. [Initials]

I acknowledge my prerogative to decline the proposed treatment. I have been apprised of, and understand, the risks associated with opting out of dental treatment. These risks encompass, though are not confined to, pain, swelling, infection, progressive bone deterioration, and eventual loss of the tooth. It has been elucidated that root canal therapies, like any dental or medical procedure, do not guarantee a 100% success rate. In the event of treatment failure, retreatment, surgical intervention, or extraction of the tooth may be required. Any deviation from the initial treatment plan may affect the associated costs, which I comprehend and accept. [Initials]

Furthermore, I comprehend that a root canal procedure necessitates the removal of a portion of the tooth structure to access and adequately treat the canal(s). I am advised to promptly seek crown coverage from my general dentist following the completion of the root canal. Failure to do so may predispose the tooth to fractures. I pledge to adhere to these instructions and acknowledge my accountability for compliance. [Initials]

Potential complications may arise during the course of treatment, including but not limited to procedural challenges, swelling, soreness, infection, trismus, paresthesia, discoloration of adjacent tissues, crown or root fractures, instrument separation, root perforation, and adverse reactions following anesthetic administration (e.g., hematoma, paresthesia, allergy, increased heart rate, etc.). [Initials]

I understand that the definitive restoration, including crown and/or filling, will be accomplished by my general dentist.

I confirm that I have thoroughly read and comprehended the aforementioned informed consent and willingly consent to undergo root canal treatment.

Patient Name: [Patient's Name] Date: [Date] Patient Signature: [Patient's Signature]