



## CONSENT FOR ROOT CANAL THERAPY

**Tooth/Teeth #:** \_\_\_\_\_

I hereby authorize Dr. Tuan Nhu to perform root canal therapy. I understand that Dr. Nhu is not a root canal specialist (endodontist), and I am declining immediate referral to a specialist at this time. I further understand that Dr. Nhu may cease treatment and make a referral to an endodontist should any unanticipated difficulty or untoward event occur during or after treatment at my additional expense. The nature and purpose of root canal treatment, including the possibility of infection which could become systemic in nature, and possible alternative methods of treatment including extraction have been explained to me, and I fully understand them.

I further understand that there are times when the diagnosis for root canal treatment is difficult and unclear. For example, fractured teeth may cause atypical tooth pain that is difficult to diagnosis. Fractured teeth may not be detected until after root canal therapy has been completed, and Fractured Tooth Syndrome may lead to the loss of the tooth. I understand that referred muscle pain, sinusitis, and other unknown conditions may mimic the diagnosis leading to root canal therapy and that sometimes elective root canal therapy is necessary in determining that diagnosis.

I understand that during the treatment I may have periods of discomfort and swelling. I also understand that multiple visits may be required to complete root canal treatment. During visits, a temporary filling material may be placed in the tooth, which may not have optimal shape and contours.

I further understand that many factors contribute to the success of root canal treatment and cannot be determined in advance. Therefore, in some cases, treatment may have to be discontinued before it is completed, or may fail following treatment.

Some of the factors which may lead to an untoward result are my resistance to infection, fracture of the tooth prior to completion of the root canal procedure and or before the definitive restorative procedure, the separation of an instrument within the tooth, the perforation of the root, and the location and shape of the canals, etc...

I have been informed that should the treatment have to be discontinued before completion, or if it fails following treatment, other procedures may be necessary to treat the tooth. These may include, but are not limited to, retreatment of the root canal or a surgical apicoectomy, root perforation repair, or even tooth extraction.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all my questions answered.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_