

Consent for Root Canal Treatment

office

I (print name) _____, hereby authorize Dr. Ronald B. Baran to perform root canal treatment on the following tooth (teeth):

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 understand that during the treatment I may have periods of discomfort and swelling.

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, 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 save the tooth, including but not limited to, retreatment or even apicoectomy might be necessary in the future. If endodontic surgery is necessary, the possible sequelae of surgical treatment have been explained. In case of an acute emergency and in the event you cannot reach this office or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

I further understand that during and following the treatment, I must follow all home care instructions, and I am to contact the doctor's office if I have any additional questions, or I experience any unexpected reactions.

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's Signature

Date

Doctor's Signature