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INFORMED CONSENT

Endodontic (Root Canal) Treatment

I have been made aware of my condition of tooth/teeth _____ requiring endodontic (root canal) treatment in the opinion of my dentist. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic diseases problems.

Some complications of root canal treatment may be, but are not limited to:

- Failure of the procedure necessitating re-treatment, root surgery, or extraction.
- Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer.
- Breakage of an instrument inside the canal during treatment, which may be left as it, or may require surgical removal.
- Perforation of the canal with instruments which may require additional surgical treatment or result in the loss of the tooth.
- Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of lip, chin, tongue, or other areas.

Some of these complications may require additional surgical treatment by a specialist and the cost of which is my responsibility.

Successful completion of the root canal procedure does not prevent future decay or fracture. An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chances of fracture.

I understand the recommended treatment, the risks of such treatment, any alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me, and I have had a chance to have all of my questions answered.

Patient Signature _____ **Date** _____

Witness _____
