HENRIETTA FAMILY DENTAL
IMPLANT & DENTAL CARE

Consent for Root Canal Treatment (RCT)

RCT has been diagnosed and recommended to me on tooth/teeth # _____ because of my:

□ Pain □ Infection □ Decay □ Broken Tooth/Teeth □ Other _____

Nature of Treatment:

- RCT (also called *endodontic* treatment) requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root(s). The procedure is performed under local anesthetic by first making an opening through the chewing surface of the tooth to gain access to the pulp. The contents of the canals are removed, and the canals are cleaned and shaped. The canals are then filled and sealed with an inert, rubbery material called *gutta percha*. Following RCT, the tooth will need a final restoration, usually a crown, to return it to its proper function.
- The intended **benefit** of RCT is to relieve my current symptoms, retain the tooth root, and permitting the tooth to be restored to proper function.

Risks of Treatment:

I understand that there are inherent risks in any medical or dental treatment or procedure, and that such risks include the following:

- Pain or discomfort, swelling, bleeding, changes in my bite, and loosening or loss of dental restorations
- New or worsened infection, requiring antibiotics or other procedures to treat
- Separation of root canal instruments inside the root canal, which may necessitate oral surgery on the tooth root
- Perforation of the tooth, tooth root or sinus by an instrument
- Injury to soft tissues adjacent to the tooth
- Nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, or tissues.
- An allergic or other adverse reaction from the anesthetic injection (i.e. temporary or permanent injury to nerves or blood vessels)

Prognosis: □ Favorable □ Questionable □ Unfavorable

Alternatives to Endodontic Treatment (Including Risks and Prognosis of Alternatives):

I understand that the two most common alternatives to root canal treatment are:

1. *Extraction.* I may choose to have tooth/teeth # _____ removed.
   Risks associated with extraction: Requires replacement by an artificial tooth by a fixed bridge, dental implant, or removable partial denture.
   Prognosis with extraction is questionable or unfavorable unless other dentistry is completed to replace the extracted tooth.
2. *No Treatment.* I may choose to not have any treatment performed.
   Risks associated with no treatment: my condition may worsen, and I may risk serious personal injury, including severe pain, localized infection, loss of the tooth and possibly other teeth, severe swelling, and severe infection that may be potentially fatal.
   Prognosis with no treatment is unfavorable as severe infection may be potentially fatal.

Acknowledgements:

By signing below, I understand the nature of the root canal procedure, possible complications, risks, and alternative treatment options.

- I acknowledge that no guarantees have been made to me concerning the results of the treatment.
- I have provided my dentist with the most accurate and complete medical, dental, and personal history possible, which includes a list of all antibiotics and other medications I am currently taking as well as those which I am allergic.
- I understand that RCT may not relieve my symptoms and that treatment can fail during or after treatment. If treatment fails, other procedures, including retreatment or oral surgery may be recommended to attempt to retain the tooth, or it may have to be extracted.
- I understand that RCT can also be performed by an endodontist (root canal specialist). If any unexpected difficulties occur during or after the treatment, I may be referred to an endodontist for further care.
- I have been given the opportunity to ask the doctor any questions regarding the root canal procedure and they have been answered fully.
- I will follow any and all pre-treatment and post-treatment instructions as explained to me, including returning to my dentist for the next step in my treatment plan. If I fail to have my tooth restored (usually crowned), I risk failure of the root canal, decay, infection, tooth fracture, and loss of the tooth.

I hereby authorize Dr. Ihab Soliman to perform root canal therapy on tooth/teeth #_____

Signed:

_____ _____

Patient or Patient's Guardian Date

_____

Treating Dentist

_____

Witness