Consent for Root Canal Treatment

Name of procedure or course of treatment:
Root canal carried out under local anaesthetic. Teeth requiring root canal are as follows;

Reason for root canal/ diagnosis:

Intended benefits of treatment: To stop or prevent pain, remove infection and restore function.

Other treatment required / may be required for the tooth:
Post: YES/NO Core: YES/NO Crown: YES/NO

Serious or frequently occurring risks
During procedure:

- Inability to gain numbness of the tooth, fracture of tooth/root, breakage of files.
- Extraction of the tooth at any point should the tooth be deemed unrestorable/complication during the treatment which can not be rectified.
- If root canal has been attempted but unable to be completed or there has been a complication, then you may be referred to a specialist/appointment rearranged.

Between visits/ after procedure:

- Bleeding, swelling, bruising, limited mouth opening, infection and pain.
- Fracture of tooth/ root which may require result in the tooth needing extracting.
- Temporary (6-12months) /permanent altered sensation or numbness of the teeth, lip, chin, tongue and gums.
- Teeth may require re-root canal should infection occur/ persist. This may require specialist referral and be at an additional cost.

Statement of Patient
I agree to the procedure as described above. I understand the information given. I understand that any procedure in addition to those described on this form will only be carried out if is necessary to save my life or prevent serious harm to my health. I have been told about additional procedures which may become necessary during my treatment. I have been given the opportunity to ask questions and these questions have been discussed and answered by the clinician.

Patient Signature: Date:

Clinicians Signature: Date:

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