CONSENT FOR ENDODONTIC TREATMENT

110-11300 No.5 Rd
Richmond, BC
V7A 5J7

t 604.274.3499
f 604.274.3477
office@endodonticcentre.com

Please review and sign the following consent form.
Your signature does not commit you to treatment.

Having had an examination including x-rays and other testing procedures, it has come to my attention that in the opinion of the endodontist at the Richmond Endodontic Centre my tooth requires root canal treatment. The reasons for needing root canal treatment have been explained to my satisfaction.

I understand the root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. During treatment, there is the possibility of a number of complications that include, but are not limited to:

- Instrument separation within the root canals
- Perforations (extra openings)
- Damage to bridges, existing fillings, crowns, porcelain veneers, or existing tooth structure
- Missed canals
- Pain, swelling, tenderness

I have been given the opportunity to opt for a second opinion, no treatment, extraction, or returning when more definitive symptoms develop. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection.

Although root canal therapy has a high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, microsurgery, or even extraction.

I understand that once root canal treatment is completed further restorative treatment will be required, which may include a post, core build-up, and crown, without which the tooth would be susceptible to fracture. It is necessary to see my general dentist within 30 days for the completion of these procedures.

Occasionally, medication will be prescribed by the endodontists of the Richmond Endodontic Centre. These medications may cause drowsiness, which can be increased by the use of alcohol or other drugs. I have been advised not to operative a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, I will stop taking the medication immediately, call the Richmond Endodontic Centre or seek immediate medical attention. I understand it is necessary to report any changes in my medical history to the endodontists at the Richmond Endodontic Centre.

I give the endodontists and staff at the Richmond Endodontic Centre permission to take photographs of the procedure. This information will be used for the purposes of documentation, education, and marketing. My privacy will be protected at all times.

Having read and considered all of the above, I hereby give my informed consent for root canal treatment by the endodontists of the Richmond Endodontic Centre.

Patient (Print Name)

First Name

Last Name

Patient (Signature)

Date

Day/ Month/ Year

(If patient is under the age of 18, the signature of a parent or guardian is required)