Permission for Root Canal Treatment: I consent to the performance of any dental procedure determined to be necessary in the opinion of the doctor and agreeable by me. I agree to ask any questions so that I will be clear as to what treatment is necessary to correct the current condition. I understand my other options are no treatment or extraction of the tooth. I also understand that only the root canal will be done at this office. The permanent restoration (filling and/or crown) will need to be done by my general dentist within 30 days unless otherwise instructed.

Informed Consent: I understand that although root canal therapy has a high degree of success there is no guarantee of healing. Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or extraction. I understand that there are certain inherent and potential risks in any treatment procedure. These risks include, but are not limited to swelling, bruising, discomfort, infection, and numbness or tingling of the lips, jaw, and/or tongue. Fractures of the tooth, existing dental work or instruments used to perform the procedure may occur. Instruments separated within the tooth may need to remain within the tooth. Additionally, variations in the canal shapes and size may complicate treatment and result in a perforation (hole) in the tooth.

I have read all of the above and have answered the above honestly and to the best of my ability.

Name____ Date _____________________

Signature ____