Root Canal Consent Form

I, _____, authorize Dr. R. Mueller to perform root canal therapy on the following tooth/teeth_____. I have given a complete and accurate medical history including all medications and drug use. I also agree to fully comply with instructions during the course of my treatment. I have been informed of the advantages, disadvantages, alternative, and risks concerning my treatment. Root canal therapy is commonly done at Dr. R. Mueller's office, this procedure is considered routine, and complications are not expected.

I realize that there is no guaranteed that root canal therapy will save a tooth, and that complications can occur from treatment. I understand that an undetectable crack in a tooth, no matter how extensive therapy may be; would lead to extraction of the tooth. A small percentage of root canals fail despite the best efforts. I understand that a specialist care may be indicated if complications arise. I understand that further restorative treatment may be necessary after the root canal, possibly including a crown to protect the tooth from fracturing. Other associated risk can include but are not limited to:

- Bruising of mouth tissues or skin of face or lips.
- Post-operative bleeding, swelling and discomfort.
- Injury to adjacent teeth or soft tissues, including existing restorations.
- Numbness of the lip, chin, gums, cheek or tongue, in most cases temporary and rarely permanent.
- Perforations into the sinus that may require additional treatment.
- Swallowing or inhaling instruments or fillings.
- Restricted mouth opening due to swelling and inflammation in tissues.
- Irretrievable broken instruments in the canal.
- Inaccessible canals.
- Fracture of the tooth requiring extraction.
- Infection or chronic irritation of the bone or surrounding and tissues.
- Non-healing lesion on the bone around the end of the tooth.
- Perforation of the canal walls or out the end of the root.

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Patient (or legal guardian's) Signature Date