Centrum DENTAL CENTRE

9-300 Earl Grey Dr., Kanata, Ontario K2T 1B9

Existing Patients (613) 599-5076 • New Patients (613) 519-3999 • CentrumDental.ca

INFORMED CONSENT FOR ROOT CANAL TREATMENT

Patient name _____

I hereby authorize _____ (doctor name) and any associates to perform a root canal on tooth/teeth number(s): _____

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatments, and the doctor has explained the risks and benefits of the alternatives. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result. The doctor has explained to me that there are certain potential risks in the procedure. These include:

1. Inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth)
2. Infection that may occur and may continue, requiring further endodontic surgery or extraction
3. Fracture or breakage of the root or crown portion during or after treatment
4. Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved
5. Perforation of the tooth or root of the tooth during treatment
6. Damage to existing fillings, crowns or porcelain veneers
7. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. I must notify this office if I experience persistent trismus or other similar concerns arise.
8. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues
9. Other:_____

Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize the doctor and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my verbal consent (except in emergent circumstances where consent might not be practical to obtain).

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

Fees

I know the fee that I am to be charged. As a courtesy to me, the office staff will help prepare the insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between the insurance company and myself and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying for all treatment in full at the time services are rendered.

Please do not hesitate to ask the doctor or the staff if you have any questions.

_____ _____

Patient signature/legally authorized representative | Date

_____ _____

Printed name if signed on behalf of the patient | Relationship