LUNAR SMILE
DENTISTRY

475 Wharncliffe Rd S, London, ON N6J 2N1
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PROCEDURE CONSENT

Consent for Endodontic Treatment

Before you sign. Read this form carefully and ask us about anything that is unclear before you sign. Your dentist will go over it with you before treatment begins. To fill it in on a computer, open it in Adobe Acrobat Reader (free), then save it and email it to info@lunarsmiledentistry.ca, or print it and bring it to your appointment.

Patient

Patient full name

Date of birth (YYYY-MM-DD)

Phone

Tooth number to be treated

About endodontic (root canal) treatment

Endodontic treatment removes inflamed or infected tissue (the pulp) from inside a tooth, then cleans, shapes and seals the canals inside the root. Its purpose is to keep a tooth that would otherwise need to be removed. It has a high success rate, but because it relies on the body healing, success cannot be guaranteed.

If you choose not to have treatment

- You may lose the tooth.
- An abscess (pocket of infection) can form and destroy the bone around the tooth.
- The infection can spread beyond the tooth and affect your general health.

Risks and limitations

1. About 5 to 10 percent of root canal treatments do not heal as hoped and need further care, such as retreatment, surgery at the tip of the root, or removal of the tooth.
2. Rarely, a fine instrument can break and stay inside a canal, or an instrument can make a small hole through the side of the root. Either can cause the treatment to fail and the tooth to be lost.
3. Making an opening through an existing crown, or placing the clamp that holds the protective rubber sheet, can damage the crown so that a new one is needed.
4. A treated tooth can still decay or break.
5. A temporary filling is often placed at first. The tooth will then need a permanent restoration, which may be a filling or a post, build-up and crown, depending on how much tooth is left.

During treatment

More than one appointment may be needed, plus separate appointments to restore the tooth. Between and after visits you may have temporary symptoms such as tenderness, swelling, pain, drainage, fever or numbness.

Local anaesthetics, pain relievers and antibiotics each carry some risk. Tell your dentist about any side effects or allergies you have had in the past.

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Please note. Some antibiotics can make hormonal birth control less effective. Use a backup method while taking them.

Your consent

Please tick each statement to confirm it is true for you.

- ☐ I have read this form, or had it read to me, and I understand it.
- ☐ My dentist has explained the procedure, why it is recommended, the possible risks, and the other options available to me, including no treatment.
- ☐ I have had the chance to ask questions, and my questions have been answered to my satisfaction.
- ☐ I understand that dentistry is not an exact science and that no particular result has been promised or guaranteed to me.
- ☐ I have given an accurate and complete health history, including medications, allergies, past reactions, and pregnancy if applicable.

Consent. I consent to endodontic (root canal) treatment of the tooth named above.

Signed by: ○ Patient ○ Parent ○ Legal guardian ○ Spouse / partner ○ Substitute decision-maker

Full name of person signing

Relationship (if not the patient)

Email

Signature

X _____

Date (YYYY-MM-DD)

Sign with the Fill & Sign tool in Adobe Acrobat Reader, or print this page and sign by hand.

For office use

Reviewed with patient by

Witness

Date