LUNAR SMILE
DENTISTRY

475 Wharncliffe Rd S, London, ON N6J 2N1
226-884-2573 · info@lunarsmiledentistry.ca
lunarsmiledentistry.ca

PROCEDURE CONSENT

Consent for Root Canal 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

Purpose of treatment

You have been told that you need root canal treatment. Its purpose is to save a tooth instead of removing it. Treatment removes the source of infection from inside the tooth, and the body then usually heals the tissue around the root. If healing does not happen, the infection can continue, and surgery at the tip of the root or removal of the tooth may be needed.

Treatment may take more than one visit, and keeping each appointment matters, because delays can let infection return. Afterwards the tooth needs a permanent restoration, often a crown, from us or your regular dentist.

Success and possible complications

Root canal treatment has a high success rate, but as with any treatment, success for any length of time cannot be guaranteed. A treated tooth may later need retreatment, root-end surgery or removal. Teeth that need retreatment have a lower success rate.

Possible complications include:

- chipping or breakage of porcelain on an existing crown or bridge;
- rarely, a fine instrument breaking inside the canal, or a small hole through the side of the root, which may need surgery or lead to the tooth being removed;
- rarely, the root splitting while the canal is being filled, which means the tooth must be removed;
- discomfort for a few hours to a few days, for which medication may be prescribed;
- swelling of the gum near the tooth, or of the face;
- a stiff jaw or limited opening;
- fracture of the root or crown of the tooth;
- filling material passing slightly beyond the tip of the root; and
- rarely, nerve injury from the freezing injection, causing tingling or numbness that is usually temporary but can be permanent.

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Other options

Alternatives include no treatment, waiting to see whether symptoms develop further, or removing the tooth. These carry their own risks, including pain, infection, swelling, tooth loss and infection spreading to other areas.

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 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