CONSENT FOR ROOT CANAL TREATMENT

_____ I hereby authorize
Patient name

_____ and any associates
Doctor name

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 during treatment.
6. Damage to existing fillings, crowns, or porcelain veneers.
7. _____

_____

_____

Unforeseen conditions may arise that require a procedure that is different than set forth above or a referral to a specialist. I authorize the doctor and any associates to perform such procedures when in their professional judgment, the procedures are necessary.

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 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.

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

_____
Patient, parent or guardian

_____ _____
Doctor Date

3/03
N-RM/708R2

Patient name:_____ Chart #:_____

Chief complaint: _____

Tooth number(s): _____

HISTORY

- ☐ Carious or mechanical exposure
- ☐ Pulp cap
- ☐ Root canal treatment begun
  - ○ Tooth left open
  - ○ Tooth sealed
- ☐ Previous I & D
- ☐ Traumatic injury
- ☐ Acute pain symptoms
  - ○ Present today ○ In past
- ☐ Chronic pain symptoms
  - ○ Present today ○ In past
- ☐ Conservative endo previously completed
- ☐ Previous endo surgery
- ☐ Hemisection/Root amputation
- ☐ Crown darkened
- ☐ Swelling
  - ○ Present Today ○ In past
- ☐ TMD pain

PAIN

- ☐ Pain today ☐ No pain today
- ☐ Pain in past ☐ No pain in past
- ☐ Pain begins spontaneously and with stimulus
- ☐ Localized pain ☐ Diffuse pain

Duration: ☐ Seconds ☐ Minutes ☐ Hours or longer ☐ Continuous

Character: _____

Intensity of pain when present

Present Pain:
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Past Pain:
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Pain increased by:
- ☐ Heat
- ☐ Cold
- ☐ Lying down
- ☐ Pressure/Biting
- ☐ Exercise
- ☐ Sweets

Decreased by:
- ☐ Heat
- ☐ Cold
- ☐ Over the counter medications

RADIOGRAPHIC SIGNS

- ☐ Normal appearance
- ☐ Caries or restoration close to or into pulp
- ☐ Widened PDL
- ☐ Lamina dura/periodontal ligament not intact
- ☐ Apical radiolucency
  _____ mm x _____ mm (HxV)
- ☐ External resorption
- ☐ Internal resorption
- ☐ Fractured root
- ☐ Osteosclerosis
- ☐ Radiolucency from lateral lesion

OTHER SIGNS and SYMPTOMS

- ☐ None
- ☐ Swelling
  - ○ Localized
  - ○ Diffuse
  - ○ Sinus tract/Stoma
  - ○ Mobility

Other _____

DATE	DIAGNOSTIC TESTS							PERIO			DATE	TREATMENT RECORD					
	No.	Perc	Palp	Cold	EPT	Hot	Tth Slth	Buccal	Lingual	Mob		No.	Canal	Reference	W.L.	Final Size	Fill

	TREATMENT NOTES