DENTAL SQUARE

8920 Highway 50, Unit E9, Brampton, ON Phone: 905-915-8988

Consent to Root Canal / Endodontic Treatment

I_____consent to treatment of myself and/or _____by _____. I acknowledge that I have been explained the nature of my or their problem and the potential treatments that could be used for this problem. I understand them to be as follows:

1. Extraction
2. Monitor if not hurting / troubling at this time
3. Specialist referral for further consultation
4. No treatment

I further acknowledge that the normal course of treatment with respect to proposed and planned treatment has been explained to me as well as normal sequelae, risks and complications.

1. Failure even with a proper / acceptable treatment (Success rate ~86% - May need extraction)
2. Acute pain on biting for a week or two
3. Broken files (Due to procedural error / Root canal anatomy) – Specialist referral would be recommended
4. Inability to completely fill (Obturate) the canals due to procedural difficulty / Root canal anatomy) - Specialist referral would be recommended.
4. Reinfection – May need extraction or Retreatment by a specialist
5. Soft tissue bruises and hematoma due to instrumentation local anesthesia and chemical used
6. Crown or root fracture if crown / cap not placed as soon as possible after completion of treatment

In the event of occurrence of any of the above complications, I know that treating doctor may need to refer me to a specialist appropriately and the costs of such unexpected treatment would be paid by me.

I have moreover received written information with respect to what was explained to me, and have read this, understood it and had the opportunity to have my questions and concerns related to the prescribed treatment answered to my satisfaction.

I understand and agree to the fees involved with this treatment as outlined and agree to the financial aspects as one of my responsibilities.

Signature: Patient or Guardian: _____

Witness: _____Date:_____