

*A.C. Villarreal Family Dental*  
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**Informed Consent**

**Endodontic (Root Canal)**

I have been made aware of my condition on requiring endodontic (root canal) treatment on tooth number \_\_\_\_\_ in the opinion of my dentist. I am aware that the practice of dentistry is not an exact science and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but is not limited to) the extraction in the involved tooth (teeth).

I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and /or other systemic disease problems.

Some complications of root canal treatment may be, but are not limited to:

Future of the procedure necessitating re-treatment, which may be left as is or may require surgery by a specialist for removal

Perforation of the canal with instruments which may require additional surgical treatment by a specialist or result in the loss of the tooth

Breakage of an instrument in the canal which would require a referral to a specialist

Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of lip, chin, tongue, or other area

Successful completion of the root canal procedure does not prevent future decay or fracture. An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chances of fracture.

I give permission for the use of local anesthetics and any anxiolytic and/or sedative medications that may be necessary. Some of the possible side effects of local anesthetic are a prolonged or permanent numbness of the cheeks, lips, tongue or gums, rapid heart rate, allergic reactions, and reactions with other drugs that you are taking.

I understand the recommended treatment, the risks of such treatment, and alternatives and the risks of these alternatives including the consequences of doing nothing. Fee(s) involved have also been explained to me and I have had a chance to have all of my questions answered.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_