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CONSENT TO PERFORM ENDODONTICS

I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. In general terms, root canal treatment is the procedure in which diseased tissue is removed from inside the tooth. The root canal is cleaned, shaped, sterilized, filed and sealed to prevent further infection and/or loss of the tooth. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

I, the undersigned, have been informed that if I require an endodontic procedure (root canal treatment) I fully understand the following:

1. Failure to follow this recommendation will most likely result in
 - a. The loss of the tooth.
 - b. Bone destruction due to an abscess.
 - c. Possible systemic (affecting the whole body) infection.
2. A certain percentage (5 to 10 percent) of root canals fail, and thereby may require retreatment, periapical surgery or even extraction.
3. During instrumentation of the tooth an instrument may break and lodge permanently in the tooth or an instrument may perforate the root wall. Although this occurs rarely, such an occurrence could cause the failure of the root canal and the loss of the tooth.
4. When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.
5. Successful completion of the root canal procedure does not prevent future decay or fracture.
6. **The permanent restoration (crown, bridge, etc.) if indicated will be completed by my general dentist in order to preserve the potential success of the root canal treatment and the function of the tooth. Failure to do so may result in root fracture and expedite the loss of the tooth.**
7. Teeth which have had root canal treatment started or completed previously may be more difficult and have a different outcome than expected under optimal conditions.
8. Additional possible complications include but are not limited to the following:
 - a. procedural difficulties in the course of treatment.
 - b. Swelling, soreness, infection, trismus (difficulty opening mouth) or discoloration of adjacent tissues.
 - c. Complications following anesthesia (bruising, numbness, swelling or allergic reaction)

All treatment will be performed in strict accordance with accepted methods of clinical practice. **Included will be the taking of a minimum of two or three x-rays for each tooth requiring root canal treatment.** My signature below serves as evidence that I have read and understand or received explanation from the doctor regarding the content of this form and thereby give consent for the performance of root canal treatment on the patient indicated.

Patient or Patient's Guardian

Date

Witness to Signature

Date