



Consent Form for Re Doing Root Canal Treatment

INFORMED CONSENT FOR REDOING ENDODONTIC THERAPY

Signing this consent form means that I hereby authorize the dentist or whomever they may designate as their assistant(s) to perform A Redoing of existing endodontic therapy as needed to treat my dental problem and/or condition.

Signing this consent form is an acknowledgement:

That the dentist has explained the likely outcomes and possible complications of each alternative option; that the dentist has made leaflets and other relevant information available to me to help with my decision making.

That the dentist has given me an opportunity to ask questions about any matters related to my treatment, raise any other concerns and given me the opportunity to postpone the treatment or seek a second opinion; that the dentist has also explained to me the options and complications related to restoring the gaps created by the extraction of teeth and the complications related each.

That the dentist has also explained to me the options and complications related to leaving the gaps created by the extraction of teeth unrestored and the complications related to this option.

That I have read understood and signed the additional Consent form for Root Canal treatment as well as for Anaesthetics.

I also understand the following:

I understand that I may also choose to decline treatment at this time and understand the risks in not having treatment at this time and understand the risks in not having treatment include, but are not limited to, pain, swelling, infection, increased bone loss, and eventual tooth loss.

In general, over 90% of routine cases are successful, however the success rate of a re-do RCT is very poor and the patient must assume failure is a very high possibility. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied.

If the case is not successful, the treatment may have to be redone, the patient may need to see a specialist, a surgical procedure maybe required, or the tooth extracted. In each instance, an additional charge will be made.

Proper post-treatment restoration (usually but not always a crown) is a necessity. The cost of this permanent restoration is not included in the cost of the Root Canal Treatment; any delay in having the permanent restoration can result in a failure of the treatment, and the need, perhaps, for an extraction.

Treatment will be performed in accordance with accepted methods of clinical practice. Included in the therapy will be the taking of a minimal number of radiographs (x-rays) as dictated by the requirements of the case. No charge will normally be made for x-rays that are taken at the practice which are part of the Root Canal treatment.

I certify that I have read fully and understand that this authorization for informed consent and I was free to ask any questions pertinent to my treatment and that these questions have been answered to my complete satisfaction.

I certify that I have been told that the cost of the Root Canal Treatment quoted includes associated x-rays and a temporary restoration (usually a dressing) and that there is an extra charge for a permanent restoration (filling or crown); and I certify that I have been told that the future permanent restoration is essential and any delay in placement can mean failure of the treatment and extraction of the tooth.

I realize that signing does not mean that I am under an obligation to have any treatment and that I may decide not to proceed with all or any part of the treatment, or that I can decide to discontinue the treatment. Similarly signing this means that I only pay for the Root Canal Treatment once it is started.

(CF Redoing Root Canal Treatment)

Patients Name _____ Date of Birth ____//____//____

Signature _____ Date ____//____//____