Informed Root Canal Therapy Consent Form

I,_____, hereby authorize Dr. John Gage to perform root canal therapy on tooth number(s)_____.

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral maxillofacial tissues. I have been advised that if the condition persists without treatment, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection, and/or premature bone loss. I have been informed of the possible alternative methods of treatment if any.

Dr. Gage has explained to me that there are certain inherent and potential risks in any root canal treatment (including the administration of any necessary local anesthetics) which include, but are not limited to:

- Postoperative discomfort and swelling that may persist for several days.
- Stretching of the corners of the mouth will result in possible cracking and bruising.
- Injury of the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side. This may persist for several weeks, months, or in some instances, permanently.
- Reinfection of the canal and/or surrounding tissue may occur requiring further treatment.
- Inability to reach and treat the end of the root
- Abscess or cyst formation
- Perforation of the side of the root
- Calcification or closure of the canal
- Fracture of the root
- Discoloration of the tooth
- It is possible for instruments to become separated during these procedures and may or may not be able to be retrieved.

Dr. Gage has explained to me that root canal treatment is usually performed in two (2) stages:

1. Removal of the infected pulp and cleaning the canal
2. Sealing the canal to prevent infection

I further understand that unless both steps are completed, the tooth can become re-infected which can lead to general health complications and the loss of the tooth. Therefore, it is curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that root canal therapy would be helpful, and the worsening of my condition would occur sooner without the recommended treatment. Because successful treatment often depends upon compliance with a doctor's instructions, I agree to cooperate completely with the recommendations of Dr. Gage and staff while under his care.

I certify that I fully understand this complete consent and have discussed my procedure with Dr. Gage. All of my questions have been answered satisfactorily and I give my consent for this procedure.

_____ _____

Patient Signature Date