Endodontic Procedure Consent Form

I, _____, hereby authorize Dr. _____ and their staff to perform endodontic (root canal) therapy and any necessary related dental procedures.

Diagnosis and Recommended Treatment

The recommended procedure is:

_____

Potential Risks and Complications

- Post-operative discomfort or infection
- Instrument separation within the canal
- Perforation of root and/or crown
- Need for further treatment or surgery
- Temporary or permanent numbness
- Other: _____

Alternatives

- Extraction of the tooth
- No treatment
- Other: _____

Patient Consent

- ☐ I have read and understand the above information.
- ☐ My questions have been answered to my satisfaction.
- ☐ I consent to the recommended endodontic procedure.

Patient Name: _____ Date: _____

Patient Signature: _____ Doctor/Witness: _____