Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

Endodontic Treatment (Root Canal)

Patient Name: _____ Date: _____

RCT #(s): _____

The purpose and method of root canal therapy (RCT) has been explained to me as well as consequences of non-treatment and reasonable alternatives. I understand that following the root canal therapy my tooth will be brittle and must be protected against fracture by the placement of a final restoration (build-up and crown). Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture. I also understand that sometimes root canal therapy may fail and further treatment may be necessary. This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had root canal treatment may require re-treatment, endodontic surgery, or tooth extraction.

I have been informed and given the opportunity to ask any questions I have in regards to the risks associated with root-canal treatment including but not limited to:

- Post Treatment discomfort, infection, and/or restricted jaw opening.
- Swelling of the gum area in the vicinity of the treated tooth or facial swelling. (Either of which may persist for several days or longer.
- Separation/ Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved. This may result in the decision to be left and used as filling material or be surgically removed.
- Perforation of the tooth during treatment which may result in additional surgical treatment or premature loss (extraction).
- Risk of temporary or permanent numbness in the treatment vicinity.
- The root canal filling material may be over or under filled, which may or may not affect the success/outcome of the treatment.

I understand that if I have been given prescriptions I am to take them as directed and that failure to do so significantly increases the chance of treatment failure, as well as pain, swelling and further infection.

X_____ Date: _____

Patient Signature

Employee/Assistant Initials: _____