SEDATION DENTISTRY NW
BRANT POWELL, DDS, PLLC
ALLENMORE MEDICAL CENTER, SUITE B-6001
TACOMA, WA 98405
(253) 572-2822

CONSENT FOR ROOT CANAL TREATMENT

Patient Name: ____

I hereby authorize Dr. Powell and any associates to perform a root canal on tooth/teeth number(s): ___________

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatment options and the doctor has explained the risks and benefits of these. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result.

The doctor has explained to me that there are certain potential risks in the procedure. These include:

1. Inability to completely fill the root canal because the canal is calcified or has a unique curvature. This may require endodontic surgery or extraction of the tooth.
2. Infection that may occur and may continue, requiring further endodontic surgery or extraction.
3. Fracture or breakage of the root or crown portion during or after treatment.
4. Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved.
5. Perforation of the tooth during treatment.
6. Damage to existing fillings, crowns, or porcelain veneers.
7. Other: ____

Unforeseen conditions may arise that require a procedure that is different than set forth above or a referral to a specialist. I authorize the doctor and any associates to perform such procedure when in their professional judgement, the procedures are necessary.

I understand that the medications, drugs, anesthetics, and prescriptions taken for this may cause drowsiness, lack of awareness and coordination. I further understand that drugs and anesthetics may cause unanticipated reactions which might require medical treatment. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not operate any vehicle or machinery until I have fully recovered from the effects of medications.

Please do not hesitate to ask the doctor or staff if you have any questions.

______________________________________ ____________________________
Patient Signature (guardian if patient is a minor) **Date**

______________________________________ ____________________________
Dentist Signature **Date**