Greenwoods™ Dental & Surgical Centres

★ **693 McPhillips Street, Winnipeg, Manitoba R2X 2H6** **(204) 774-7774** **Fax (204) 633-1143**

249½ Henderson Highway, Winnipeg, Manitoba R2L 1M3 (204) 775-7775 Fax (204) 667-6229

246 Portage Avenue, Winnipeg, Manitoba R3C 0B1 (204) 779-7779 Fax (204) 594-5768

1531 Pembina Highway, Winnipeg, Manitoba R3T 2E5 (204) 221-2221 Fax (204) 504-5111

1462 Regent Avenue West, Winnipeg, Manitoba R2C 3A8 COMING SOON

1128 Richards Street, Vancouver, BC V6B 3E6 (604) 566-7666 Fax (604) 566-7660

First Name _____ Last Name _____ Date of Birth _____

Root canal treatment has been recommended for me on the following tooth (teeth): _____

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wishes have also been taken into consideration. Root canal treatment is necessary because of:

☐ Pain ☐ Infection ☐ Decay ☐ Broken teeth

☐ Other : _____

RISKS OF ENDODONTIC TREATMENT

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 treatments, and the doctor has explained the risks and benefits of the alternatives. 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:**

- 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).
- Infection that may occur and may continue, requiring further endodontic surgery or extraction.
- Fracture or breakage of the root or crown portion during or after treatment.
- Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved.
- Perforation of the tooth or root of the tooth during treatment.
- Damage to existing fillings, crowns or porcelain veneers.
- As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues.

- Other _____

ACKNOWLEDGMENT

I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered.

I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I understand the risks and elect to have this procedure performed by Dr. _____ . I understand that if any unexpected difficulties occur during treatment, I may be referred to an endodontist for further care.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE

_____ _____

TREATING DENTIST SIGNATURE DATE