



LUMA DENTAL

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ROOT CANAL CONSENT

Patient name: _____ **Tooth #** _____

I understand that root canal treatment is an attempt to save the tooth due to loss of vitality from infection, traumas, or decay. This procedure and its alternatives have been explained to me and I have been informed that occasionally there are complications concerning this treatment.

Possible risks and complications of this treatment include allergic reactions to medications or anesthetics, pain, swelling and sensitivity to pressure and other discomfort during or after the root canal is sealed. Treatment may be modified or discontinued due to calcified roots, inaccessible canals, fractured of the roots or crown of the tooth, perforation, resorption or instruments separated in the root.

I understand that in a few cases a surgical procedure may be indicated to seal otherwise inaccessible canals or to remove infected apical portion of the root canal treatment. The natural crown of the tooth may darken eventually and/or become brittle and may even fracture following the root canal treatment.

Therefore, I understand the importance of having the tooth (s) restored as soon as possible with a crown or permanent filling.

Alternatives to root canal treatment are extraction or no treatment. A root canal infection left untreated may cause serious symptomatic infection which could endanger my overall health even cause death.

The dental care and treatment has been fully explained to me and I understand the risks involved. I understand what is to be done and there is no warranty or guarantee as to any result and/or cure.

I have read and understand the terms and conditions of treatment. I consent to the root canal treatment including the use of local anesthetic and all required x-rays.

Patient's signature

Date



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