ROBERT T.
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Family Dentistry
For Everyone With
Care & Concern
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383 W. DRAKE RD
FORT COLLINS, CO 80526-2884
SATURDAY APPTS.

ROOT CANAL THERAPY CONSENT

I understand that root canal therapy is a procedure necessary to retain tooth/teeth _____, which would otherwise require an extraction. Although root canal therapy has a very high success rate, it is a biological procedure in which the results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction (which may require a referral to a specialist in this field).

I am aware that the root canal therapy is to be performed in this office and the fee for this service is _____.

I also understand that the root canal treated tooth will require a permanent restoration (post and core, crown, etc.). This is necessary to protect the tooth from fracture or recontamination of the root canal system and should be done as soon as feasible.

All of my questions have been answered and I fully understand all of the above statements in this consent form.

_____ _____

Signed: Patient, Parent, Guardian or Agent Date

ROOT CANAL THERAPY CONSENT