



CONSENT FOR ENDODONTIC THERAPY

Patient's Name _____

Tooth # _____

Please review the following consent. You will be required to sign it prior to the initiation of treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by Dr. _____ and any assistants required. I agree to the use of local anesthesia, depending on the judgment of the endodontist. I understand the endodontist will consult with me prior to the administration of any sedation. Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), exacerbation of temporomandibular joint disorders, infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

I understand that root canal therapy is a procedure to retain a tooth which might otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction due to such unforeseen occurrences such as fractures, calcified canals or uncontrollable pain or infection. Following treatment, the tooth may be brittle and subject to fracture. (A RESTORATION-FILLING, CROWN, AND/OR POST AND CORE WILL BE NECESSARY TO RESTORE THE TOOTH TO FUNCTION; THIS WILL BE PERFORMED BY THE GENERAL DENTIST).

Fees are quoted in advance of treatment. If this has been neglected, please don't hesitate to ask. Fees remain the same except:

1. When appointments are broken without proper advance notification.
2. If surgery or retreatment becomes necessary.
3. When cancelled appointments are not rescheduled with our office.

If for any reason you will not be able to be treated for one month between visits, this may lead to further complications, possible recurrent or persistent infection, which may lead to increased chance of failure or loss of tooth. Once this happens other expenses will be incurred to re-initiate treatment, but likelihood of success decreases. Therefore, sequence of treatment is an important factor in the success of your treatment.

During treatment there is a possibility of instrument separation within the root canals, perforations, damage to bridges, existing fillings, crown or porcelain veneers, missed canals, loss of tooth structure in gaining access to the canal(s), and fractured teeth. Also there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness, which may be increased by the use of alcohol or other drugs. I am advised against operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives or intestinal problems, and if any of these reactions occur, I am to call the office immediately. I understand that it is my responsibility to report any changes in my medical history to the office.

I also acknowledge full responsibility for the payment of such services and agree to pay for them in full prior to the completion of the treatment. If you have insurance, we require the payment to be sent directly to us and we will collect your **ESTIMATED** co-payment plus deductible at the time of service. I give permission to Cape Cod Endodontics, P.C. to call my insurance company and/or general dentist to verify my insurance benefits and eligibility. I agree to the release of my dental/medical records if necessary.

PLEASE DO NOT WRITE IN THE SPACE BELOW UNTIL YOU HAVE READ AND UNDERSTAND ITS CONTENTS.

If there is anything that you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions, please write them in the space provided. If you have no question, please write "NONE".

Signature: _____

Date: _____

All signatures must be by a parent or guardian if the patient is under the age of 18.