



## CONSENT FOR INITIAL EXAMINATION

Patient's Name \_\_\_\_\_ Tooth # \_\_\_\_\_

I, \_\_\_\_\_, do hereby give my consent to Dr. \_\_\_\_\_ and any assistants required to perform an initial endodontic examination prior to any definitive treatment.

This consent is for evaluation only and no invasive treatment will be performed prior to discussion of any proposed treatment with the doctor(s) and appropriate staff.

I understand that diagnostic radiographs may be needed at the doctor's discretion. I also understand that the doctor may require consultation with other dental and medical professionals prior to the initiation of any definitive treatment.

This initial evaluation consists of: examination of diagnostic radiographs, pulp vitality testing, localized periodontal examination and definitive treatment planning.

I understand that in some instances a local anesthetic may be needed for diagnostic purposes. This will not be performed without prior notice and discussion with the doctor.

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PLEASE DO NOT WRITE IN THE SPACE BELOW UNTIL YOU HAVE TALKED TO THE DOCTOR TREATING YOU.**

The need for local anesthesia has been discussed and I consent to its use.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_