ADVANCED ENDODONTICS
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Endodontic Informed Consent

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1) Pain, swelling and discomfort after treatment;
2) Infection in need of medication, follow-up procedure or other treatment;
3) Damage to the existing crown, requiring the fabrication of a new crown by your dentist;
4) Possible deterioration of your condition which may result in tooth loss;
5) Possible injury to the jaw joint and muscles of mastication requiring follow-up care and treatment, or consultation by a dental specialist;
6) Separation or fracture of a file or dental instrument that may be left in your tooth, and may have to be removed surgically at a later time if symptoms develop;
7) Root fracture, or perforation which may result in tooth loss;
8) Allergic reaction to latex, anesthetic or medication;
9) Need for follow-up treatment, including surgery.

The goal of endodontic root canal treatment is to retain a tooth that may otherwise require extraction. Although root canal treatment has a high degree of clinical success, it is a dental-biological procedure, whose results can not be guaranteed. Occasionally, root canal treatment may fail, resulting in tooth loss. Upon completion of the root canal treatment, you have to notify your referring dentist so that a permanent crown can be made for the root canal-filled tooth within the one-month period. Failure to properly restore the tooth may lead to fracture and eventual loss of the root canal-filled tooth.

I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

Patient's Signature ________________________________ Today's Date ______________________

I consent to have the following endodontic procedure performed: ______________________________
I understand the cost of this procedure is ___________, and accept full responsibility for the payment of my treatment whether or not paid by my insurance. A 35% surcharge will be added to your account if your account is turned over to a collection agency.

Authorization

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

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Patient's Signature or Signature of Patient's Parent or Legal Guardian (if a minor) — Dentist's Signature

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