DOCS
DENTISTRY ON CATHERINE STREET

CONSENT FOR ROOT CANAL

I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Occasionally, a patient may experience post-operative discomfort or swelling which may require medications for several days. Although root canal treatment has a very high degree of success, it is still a biological procedure, and as such, cannot be guaranteed. Some teeth that have had root canal treatment may require retreatment, surgery, or even extraction.

I also understand that only root canal treatment is to be performed in this office. The permanent (outside) restoration (filling, crown, onlay, etc.) will be performed by my regular dentist.

Tooth/Teeth Treated _____ Fee (Estimate) _____

Risks and Complications: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Nerve injury, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.

No Warranty or Guarantee: I understand that the doctor cannot guarantee the results of the procedure.

Consent to Unforeseen Conditions: During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

Compliance with Self-Care Instructions: In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non- prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good oral hygiene, keep all appointments, make return appointments if complications arise and complete care. I will inform my doctor of any post-treatment problems as they arise. My failure to comply could result in complications or less than optimal results.

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to the root canal procedure as presented to me during the consultation and treatment plan presentation by the dentist.

You or your responsible party will have the opportunity to sign an electronic copy of this form when you arrive at our office for your appointment.