NON-SURGICAL ENDODONTIC CONSENT AND INFORMATION SHEET

1. Root canal therapy is treatment performed to retain a tooth that might otherwise require extraction. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction.

2. During root canal therapy, certain procedural complications can occur including, but not limited to: alteration of sensation (numbness), separated (broken) instruments, blocked/calcified canals, perforation of the crown and/or root, and damage to restorations. During treatment complications may be discovered which make treatment impossible, or which require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, curved roots, periodontal (gum) disease, and splits/fractures of the teeth.

3. Local anesthetics will be used during root canal therapy. Some common side effects include pain, swelling, and bruising. Other rare side effects may include convulsions, weakness, allergic reactions, persistent numbness, and injury to blood vessels.

4. Although root canal therapy has a high degree of success, it is still a biological procedure and as such, cannot be guaranteed. Some teeth that have had root canal therapy may require retreatment, surgery or even extraction.

5. I understand only root canal treatment is to be performed at this office and that the final restoration (filling, crown, etc.) will be done by my general (family) dentist.

6. I understand that the dentist performing the treatment is a specialist in this field.

7. Financial Agreement: Tooth (teeth) number (s): _____

   ESTIMATED FEE: _____ ESTIMATED Insurance: _____

   ESTIMATED Patient Co-Payment: _____

   Patients with dental insurance will be responsible to pay the estimated insurance co-payment at the beginning of treatment and authorize the assignment of the insurance benefits to us. After insurance benefits are received, if there is an overpayment, a refund will be sent to you. If there is an additional amount due we will send a statement for the balance. Unpaid balances older than sixty days are sent to collections at additional expense to the patient. Patients with no dental insurance may pay half of the total fee at the beginning of treatment and the remaining balance before completion of treatment, unless treatment is completed in one visit.

8. All of my questions have been answered by the doctor and I understand the above statements in the consent form. I hereby give my consent to the performance of endodontic therapy on the tooth or teeth listed above. I further give my consent to the administration of medications, anesthetics, drugs and services deemed necessary to treat my endodontic problem.

Patient/Parent Signature _____Date: _____