New England Dental

Family Dentistry • Se Habla Espanol • Falamos Portuguese

INFORMED CONSENT / ENDODONTIC TREATMENT

Dr.________________ has been explained the benefits and risks of endodontic treatment to me. Referral to a specialist (endodontist) has been offered. I understand that endodontic treatment involves the removal of tissues in the center of the tooth (root canal) and the sealing of the space that is created during the process of removal and cleansing of the root canal system. I further understand that the root canal treatment may fail if proper restoration of the tooth is not completed after the root canal treatment is done, and that such restoration is a separate and distinct procedure with an additional fee.

I understand and accept the treatment recommended for me by Dr. _________________. I further understand that there may be some unwanted complications, some of which are listed below. No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I understand that an alternative treatment may include extraction of the involved tooth or teeth. I understand the risks of no treatment include, but are not limited to infection, swelling, cyst formation, pain, and loss of the tooth/teeth and/or systemic disease. All of my questions have been addressed.

Proposed fees have explained to me, as have any third party insurance benefits. I understand that third party benefits may be different than discussed by Dr. _________________, as they are not under control of this office.

- Treatment risks / unwanted consequences may be (but are not limited to):
- Reaction to medications / anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, tongue or other areas
- Potential for re-treatment of the root canal or possible surgical treatment
- Instrument breakage in the tooth / perforation of the root(s)
- Recurrent decay
- Color of the tooth may change (became darker than adjacent teeth)
- Post treatment swelling and / or pain
- Post treatment infection
- Root fracture / crown fracture

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient Name: ____ ID # __________________

Patient Signature: ______________________________________ Date: _________________

Witness: ____ Date: _________________

Doctor Signature: ______________________________________ Date: _________________

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