

MT. TABOR DENTAL, L.L.C.
Todd L. Beck, DMD

CONSENT FOR ENDODONTIC TREATMENT

The Endodontic (Root Canal) procedure to be performed,

has been explained to me to my satisfaction, and I understand the explanation.

Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery or even extraction. These additional procedures may include referral to another dentist for consultation or treatment. I understand the procedure, associated risks and alternatives regarding this endodontic treatment, and I have no unanswered questions regarding this therapy. I understand that the need for any of these additional procedures, are not a sign of incomplete or improper treatment, but one of recognized statistical complication. I am aware that I can request referral to an endodontic specialist for this procedure. Furthermore, I understand that I can ask for a more detailed recital of risks and alternatives to this procedure if I so choose.

I have been advised that following root canal therapy, a post and/or core build up restoration and full crown coverage is normally necessary in order to protect and preserve the root canalled tooth. I also understand that a present filling or crown, on this tooth, may need replacement following root canal therapy. Any such additional treatment will involve additional charges.

Other treatment choices include: no treatment, delaying treatment while waiting for more definitive symptoms or having the tooth extracted. Risks of root canal therapy and these other choices include: pain, swelling, infection, loss of tooth , infection to other areas and surgical complications (such as root perforation, separation of instruments, etc.).

I further consent to the administration of local anesthesia, antibiotics, pain relievers or other drugs that may be deemed necessary. I understand that there is an element of risk inherent in the administration of any drug or anesthesia.

I realize that it is mandatory that I give an accurate and complete medical and personal history and follow any and all instructions as directed.

Patient Name (please print)

Patient Signature

Date

Witness Signature