

**NON-SURGICAL ENDODONTIC THERAPY INFORMED CONSENT**

I understand that root canal therapy is a treatment performed to retain a tooth which might otherwise require extraction. Root canal treatment removes the pulp tissue (nerves and blood vessels) inside a tooth, then seals the space with a filling material. During root canal therapy, certain procedural complications can occur including, but not limited to, alteration of sensation, i.e., numbness, separated instruments, blocked canals, root perforations, and damage to restorations. A patient may experience post operative discomfort or swelling and may require medications for several days. 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 treatment, surgery, or even extraction.

I understand that only root canal therapy will be performed in this office. A subsequent restoration (filling, crown, onlay, etc.) will be needed and will be performed by my general dentist.

**PATIENTS WITHOUT DENTAL INSURANCE**

I understand that I am responsible for payment of the fees for services rendered.

**PATIENTS WITH DENTAL INSURANCE**

When treatment is started the staff will be asking me for a patient initial payment along with an insurance claim form which I must have filled out completely and accurately, assigning benefits to the attending dentist. The staff will then complete the dental portion and forward the claim to the insurance company on the day my root canal therapy is completed. After payment has been received from the insurance company, I will either receive a bill for any remaining balance or a refund check if the insurance company has paid more than anticipated. I further understand, that if, for any reason, my dental claim is rejected I am responsible for payment in full for all fees incurred.

Tooth Treated \_\_\_\_\_  
Patient Initial Payment \_\_\_\_\_ Fee \_\_\_\_\_  
Signed By \_\_\_\_\_ Date \_\_\_\_\_  
                  patient, parent, guardian (please circle)  
Signed By \_\_\_\_\_ Date \_\_\_\_\_  
                  Doctor  
Signed By \_\_\_\_\_ Date \_\_\_\_\_  
                  Witness