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. 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. Further, in my particular case, I have been informed that the prognosis for my tooth #_____is not good, and therefore it is quite possible that in spite of all treatment attempted to retain the tooth it will be necessary to extract it. Nevertheless I have chosen to undergo endodontic treatment and accept full financial responsibility for the treatment regardless of the outcome.
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 INSURANCF:

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 mv root canal therapv 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.

Tooth Treated___________________________

Patient Initial Payment _______________________Fee___________________________

Signed By____Date______________________
patient, parent, guardian (please circle)
Signed By____Date________________________
Doctor
Signed By____Date__________________________
Witness