dentist @ W2

CONSENT FOR ENDODONTIC CONSULTATION, X-RAYS, DIAGNOSIS OR TREATMENT (NON-SURGICAL OR SURGICAL ENDODONTICS)

PLEASE READ AND SIGN

Having had an examination and/or x-ray, and other testing procedures, it has come to my attention that in the opinion of Dr_____my tooth#_____requires root canal treatment to restore the tooth.

The reason for needing root canal treatment is_____.

I have been explained to my satisfaction and I understand that during, or after, the treatment I may have periods of discomfort.

I understand that in spite of the efforts this tooth may require further canal surgery, root canal treatment, or perhaps extraction at a future date. I understand that many factors contribute to the success or failure of root canal therapy which cannot be determined in advance. Some of these factors include, but are not limited to, my resistance to infection, the location and shape of the root canal anatomy, my failure to keep scheduled appointments, the failure of my having the tooth restored following the treatment, periodontal (gum) involvement, or an undetected or after the fact caused split (crack) in the tooth.

I further understand that once root canal treatment is completed further restorative treatment will be required, which may include a post/core build up and crown, without which the tooth would be very susceptible to fracture. However, I understand that in the event of complications within my tooth structure, a referral to endodontist may be necessary.

Having read and considered all of the above, I hereby give my consent for root canal treatment by Dr._____.

_____**Date:**_____

Patient's signature (if a Minor, Signature of Parent or Guardian)

_____

Relationship to the patient

_____ _____

Witness Signature **Dentist's Signature**