Endodontic Associates of Greater Washington

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Endodontic Consent

PATIENT INFORMATION					
First Name		Last Name		Birth Date	

CONSENT FOR ENDODONTIC EVALUATION ONLY

I understand my tooth will be evaluated for possible endodontic treatment.

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Patient Signature (Parent if minor)

CONSENT FOR ENDODONTIC / EMERGENCY TREATMENT

I understand that the root canal therapy is a treatment performed to retain a tooth which might otherwise require extraction. I have been informed of possible alternative methods of treatment including no treatment at all.

During root canal therapy, certain procedural complications can occur including but not limited to, i.e., numbness, separated (broken) instruments, blocked canals, root perforations, alteration of sensation, and damage to restorations.

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 re-treatment, surgery, or even extraction.

I understand that only the root canal treatment is to be performed at this office and that my restorative dentist will do the follow up treatment (filling, crown, etc.).

I understand that the dentists performing the endodontic treatment are specialists in this field.

FORM COMPLETION			
I understand and agree to this Consent to Endodontic Treatment.			
Signature of Patient, Parent or Guardian		**Date**	
IF PATIENT IS A MINOR			
Form signed by		**Relationship to Patient**	
Witness Signature			