

## **MUTUAL UNDERSTANDING / CONSENT FOR TREATMENT**

I, the undersigned, after consulting with the doctor, consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor.

I understand that root canal treatment is an attempt to save a tooth which otherwise requires extraction. Elective root canal therapy may be performed to provide space to anchor a final restoration and/or crown when insufficient tooth structure remains or to relieve excessive sensitivity to temperatures or as an adjunct to other specialty treatment. Although root canal therapy has a high degree of success, it is still a biological procedure, so success cannot be guaranteed or warranted. Occasionally, a tooth that has had a root canal may require retreatment, surgery or even extraction.

It will be explained to me that there are certain inherent and potential risks in any treatment or procedure, including extraction and/or dental implant placement which may be alternative treatments instead of root canal therapy. I understand that the following may be potential risks of root canal treatment: numbness and/or a tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasion may be permanent; treatment failure; complications resulting from the risks of dental instruments (broken instruments, perforation of the tooth, root or sinus); and antibiotics may inhibit the effectiveness of birth control pills.

Swelling or discomfort may be experienced after treatment by some patients. There is no way to predict this. Prescriptions for pain killers and/or antibiotics will be provided if needed.

I will have an opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment and the alternatives to this treatment.

***I also understand that only the root canal will be done in this office. The permanent (outside) restoration (filling and/or crown) needs to be done by my regular dentist within a maximum of an 8-week period.***

I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at or before the completion of treatment, unless other specific arrangements are made with this office.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Parental Permission \_\_\_\_\_