PATIENT INFORMATION AND CONSENT FORM

We believe that a patient must be well informed about any treatment and their consent is given before starting the treatment. The purpose of this form is to inform you of the risks and complications that occur, on infrequent occasions during a root canal treatment.

Endodontic treatment (root canal) is performed in an attempt to save a tooth which otherwise might require an extraction. Although endodontic treatment has a degree of success, no guarantee can be given. Root canal treatment generally takes one to two visits and requires local anesthetic and a few x-rays.

In some cases, the tooth may require retreatment, apical surgery or even extraction in case of retreatment, some complications may be encountered due to previous treatment such as blockage, perforation or broken instrument that may need apical surgery or extraction. Root fractures are also one of the main reasons for the failure of a root canal therapy. Unfortunately some cracks that extend from the crown down into the roots are invisible and undetectable. Whether the fracture occurs before or after the root canal treatment, it may require an extraction. If a surgical approach becomes necessary at any time during the course of treatment or recall period, a separate fee will be quoted.

Following completion of endodontic treatment, you must return to your dentist for placement of appropriate restoration for the treated tooth. It is emphasized that this be done as soon as possible (recommended between 10-20 days) in order to protect the tooth from subsequent fracture or decay.

Root canal treatment is a very safe and effective procedure. On infrequent occasion, however, there are certain inherent and potential risks that may occur during on after the procedure such as; pain and swelling, sensitivity; infection and bleeding cheek, which is transient but seldom; discoloration of tooth; sinus or tooth perforation; broken instrument; calcified or curved canals that cannot be negotiated; treatment failure; reaction to anesthetic or medication; discoloration of the face; and also antibiotics that may inhibit the effectiveness of birth control pills.

Other treatment choices include; no treatment; wait for more symptoms that may cause pain, infection, swelling, loss of the tooth or extraction that may cause shifting and movement of other teeth; and difficulty of chewing.

During your course of treatment, every effort will be made to achieve successful results and to keep you as comfortable as possible.

I acknowledge having read the forgoing and understand its contents.

PATIENT / PARENT SIGNATURE _____ **DATE** _____

BROKEN APPOINTMENT FEES

ALL INSURANCE CARRIERS ALLOW FEES FOR CANCELLED OR BROKEN APPOINTMENTS. THOSE FEES VARY FROM $40.00 TO $60.00 PER APPOINTMENT.

APPOINTMENTS FOR SPECIALTY CARE ARE IN DEMAND. WE REQUIRE A 24 HOUR NOTICE IN ADVANCE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT.

IF YOU FAIL TO PROVIDE 24 HOURS NOTICE, YOU WILL BE CHARGED FOR THE MISSED APPOINTMENT.

PATIENT / PARENT SIGNATURE _____ **DATE** _____

DENTAL HISTORY

PATIENT NAME _____ EMAIL _____

1. Have you ever had a local anesthetic (Novocain, etc.)? YES **NO**
2. Have you ever had any unfavorable reaction from a local anesthetic? YES **NO**
3. Have you had any serious trouble associated with any previous dental treatment? YES **NO**

   If so, explain? _____

4. Does dental treatment make you nervous? Slightly Moderately Extremely? YES **NO**
5. Would you desire to be pre-sedated? YES **NO**

To the best of my knowledge, all of the preceding answers are to and correct.

PATIENT / PARENT SIGNATURE _____ **DATE** _____

CONSENT FOR TREATMENT

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Medical History form, to administer such anesthetics, analgesic, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

ALL SERVICES ARE RENDERS AND ACCEPTED UNDER THE TERMS AND CONDITIONS PRINTED ON THE REVERSE HEREOF:

SIGNED _____ DATE _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.