DECK DENTISTRY | Consent for Endodontic Treatment (Root Canal)

I, _____ hereby authorize Dr. _____
Print Patient Name

to perform Endodontic Treatment on _____
Tooth/Teeth

The Dentist and/or Treatment Coordinator, Susie has explained the nature and purpose of the endodontic treatment to me, and I fully understand them. I understand that the other treatment alternatives include no treatment at all or the extraction of the tooth.

I understand that many factors contribute to the success of Endodontic Treatment and that no dentist can guarantee results. Therefore, in some cases treatment may have to be discontinued before it is completed, or, may fail following treatment. Some of these factors may include: my resistance to an infection, the location and shape of the canals etc.

I have been in formed and understand that in the event of the Endodontic Treatment, the existing restoration (filling, post, core, or bridge) may have to be damaged and removed and will subsequently require repair or a complete replacement.

In such event I, _____, will be financially responsible for the replacing of the existing restorations.

I have been informed that should the treatment have to be discontinued before completion, or if it fails following the treatment, other procedures may be necessary to save the tooth. Although unlikely to occur, on occasion some teeth may have to be extracted because the treatment was unsuccessful.

I hereby consent to the taking of diagnostic records, including radiographs (x-rays) before, during and after endodontic treatment, to the application of local anesthesia, and to Dr. _____ providing Endodontic Treatment for _____ Tooth/Teeth.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____ _____
Dentist's Signature Date