



CONSENT TO ENDODONTIC THERAPY

Please review the following consent and sign it; however, it does not commit you to treatment. If you have any questions or if there is anything you do not understand about the endodontic procedure, please ask the doctor when he or she reviews your treatment and options during your appointment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists employed by Palmetto Endodontics, LLC and any assistants with whom they work. I agree to the use of local anesthesia, depending upon the judgment of the endodontist. I understand the endodontist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. Complications of root canal therapy and anesthesia may include swelling, bruising, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which is rarely protracted and even more rarely is it permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction and that as a specialty practice; the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth to function; your general dentist will perform this. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, or porcelain veneers, missed canals, loss of tooth structure in gaining access to the canals and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medications will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating and vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

With regards to financial obligation, I understand that I am financially responsible for charges related to examination and/or treatment at the time services are rendered. In the event insurance is a factor, I agree to be responsible for all charges for dental services and materials not paid for by my dental carrier. Any fees associated with collecting a past due balance may also be assessed to my account. These fees include but are not limited to fees charged by a collections agency, attorney fees, certified letter fees or any court fees.

Printed Name: _____

Signature: _____

Date: _____

OFFICE USE ONLY

Pt Chart #: _____

Witness: _____