Lakeside Endodontics, P.A.

TREATMENT/CONSULTATION CONSENT

I have been **EDUCATED** and **INFORMED** about the root canal treatment and/or consultation for which I am **giving my consent** and I **understand** the risks that are involved in performing this procedure. Specifically, I have been informed that:

1. There is about 5% chance that my root canal therapy may not work. If the root canal fails, I may need additional treatment or extraction of the tooth. The fee charged for this root canal does not cover additional treatment.
2. Any of the root canal instruments may break inside my tooth.
3. An instrument may create a hole, called a perforation, through the crown or root of the tooth.
4. A crown, bridge, veneer (cosmetic cover), natural crown, a dental restoration or my natural tooth may break or crack due to root canal treatment.
5. The Endodontist may encounter complications which may include but not limited to:
    a. Blocked Canals b. Natural Calcifications (hardening) c. Badly Curved Canals
    d. Split Roots or Fractured Canals e. Periodontal Damage or Infection
    f. Broken Instruments from a Previous Treatment g. Temporary or Permanent Nerve Damage (my lip may remain numb even after the procedure)
6. Any complications (listed above) and/or problems may require me to have additional treatment or surgery.
7. Complications may make it impossible to complete the root canal. If this is the case I realize there may be an additional fee for the time spent attempting the root canal.
8. I have the option of **REFUSING TREATMENT** at time of consultation or extracting the tooth.
9. Teeth that require further treatment or re-treatment have a lower rate of success.
10. A tooth with a root canal should have a permanent restoration and you will need to follow up with your general dentist.
11. I have been informed about the medications the Endodontist may prescribe to me and of their possible side effects. I will follow all instructions given to me.
12. I agree to return promptly to have my root canal completed. I realize that if I fail to show up, or if I cancel future appointments and do not return, that I am still **responsible for the full fee** of the procedure.
13. If I fail to show up for a scheduled appointment, I take **full responsibility** for any serious consequences, such as hospitalization from infection, and will not hold the Endodontist responsible for my actions.

I have had all my questions answered regarding this procedure/consultation and its potential risks to me. I understand this consent form and the staff have answered all of my questions related to this procedure/ consultation. I give permission to the Endodontist to perform this procedure/consultation.

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Name of Patient (PRINT) Parent/Patient Signature

_____ _____

Witnessed By (Office Staff) Date