Authorization and Consent to Treatment and/or Surgery

Patient's Name: _____ Date:_____

This is my consent for the dentist(s) and staff at Greenville Endodontics to perform a consultation and/or dental procedure(s) as indicated by the Doctor's examination with my verbal approval. I understand that, although root canal therapy has a high degree of success, it is still a biological procedure, so results cannot be guaranteed. I understand that because people are different and each individual responds to dental care in a different way, that a prediction of the exact results of the treatment is not possible. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery or even extraction. I understand that I will always have the option of extraction or declining treatment instead of the recommended treatment. At any time during the treatment, if root canal therapy is determined to be not an optimal treatment for the tooth, the doctor may suggest an alternate treatment plan and the treatment performed so far will be considered incomplete treatment. I also have been informed that root canal treatment may require more than one appointment to complete depending on the complexity of the tooth.

I have been informed and understand that there are certain inherent and potential risks in any treatment procedure. These risks include, but are not limited to, discomfort, swelling, bruising, bleeding, infection, and numbness or tingling of the jaw. Fractures of existing restorations, teeth, and/or instruments used to perform the treatment may occur. Additionally, variations in canal shapes and size may complicate treatment and result in a perforation (hole) in the root or root canal filling that is less than desirable.

I understand that the permanent restoration (filling/crown) will be done by my general dentist following the root canal therapy. (Upon completion of root canal treatment, the patient should wait an average of two weeks, unless directed otherwise). In the course of treatment, if an existing permanent crown comes loose or if the doctor decides to section the crown, I will not hold Greenville Endodontics and its staff responsible for any consequences including but not limited to both repair and replacement of the crown. The patient is responsible to see his general dentist for a new crown.

I authorize my insurance carrier to issue the dental benefits of my plan directly to the dental office. I also authorize release of information necessary to process dental insurance. I understand that regardless of insurance, I am responsible for the total amount for the treatment done.

_____ _____

Signature of the Patient/Parent/Guardian(If patient is a minor) Date:

_____ _____

Witness Signature Endodontist's Signature