Authorization and Informed Consent for Endodontic Therapy

Please review the following. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

I (patient's name)_____hereby authorize Dr. Johnson and whomever he designates as his assistant (s) to perform endodontic therapy as needed to treat my dental problem or condition. I further authorize the administration of medications and anesthetics, performance of diagnostic procedures, and such additional services that may be deemed reasonable and necessary, understanding that risks are involved.

Possible alternative methods of treatment may include the following: endodontic surgical procedures, tooth removal, or no treatment, and the advantage or disadvantages of each will be discussed. I understand that I may also choose to decline treatment at this time and understand that the risks in not having treatment include, but are not limited to, pain, swelling, infection, increased bone loss, and eventual tooth loss.

I also understand the following:

In general, over 90% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied. If the case is not successful, the treatment may have to be redone, a surgical procedure may be required, or the tooth may have to be extracted. In each instance an additional charge will be made.

Cases started in other offices or retreatment cases are usually more difficult and may have a different outcome than expected under optimal conditions.

It is usually necessary to alter the tooth structure or remove the restoration (e.g. crown or filling) of the tooth being treated. Proper post-treatment restoration (filling, onlay, crown, etc.) is a necessity. I also understand that only the Root Canal Treatment is to be performed at this office. It is my responsibility to contact my referring dentist soon after completion of the endodontic treatment to arrange for post-treatment restoration.

Treatment will be performed in accordance with accepted methods of clinical practice. Include in the therapy will be the taking of a minimal number of x-rays as directed by the requirement of the case.

Periodic recall examination is often recommended to evaluate the healing after treatment and no further charges are made for it. Compliance, however, is the responsibility of the patient.

Possible complications of treatment include, but are not limited to the following:

a. procedural difficulties in the course of treatment;
b. swelling, soreness, infection, trismus, paresthesia, or discoloration of the adjacent soft or hard tissues;
c. fracture of the crown or root of the tooth or restoration;
d. fragmentation of the root canal instruments during treatment;
e. perforation of the root with instruments;
f. complications following local anesthetic injection (hematoma, paresthesia, allergy, increased heart rate, etc.); and
g. additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.

Should I elect to proceed with treatment recommended, I certify that I have read and understand the above Authorization and Informed Consent Form information and have addressed concerns pertinent to my treatment.

Signature:_____ Date:_____
Patient or Guardian (if patient is a minor)

(Form-R-2018)