LA JOLLA VILLAGE
Endodontics

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CONSENT TO ENDODONTIC (ROOT CANAL) THERAPY

Please review the following consent. It is our belief that you should be informed about the proposed treatment and the risks and alternatives prior to starting treatment.

ROOT CANAL THERAPY is intended to allow you to keep your tooth for a longer period, which will help to maintain your natural bite and the healthy functioning of your jaws. Treatment will be done in a manner to minimize or avoid risks. Although root canal therapy has a high degree of success, the results cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

ALTERNATIVES to root canal therapy include no treatment, waiting for more definitive symptoms to develop, or extraction. Risks involved in these alternatives include but are not limited to pain, swelling, infection, and loss of the tooth. Extraction of the tooth may require replacing the tooth with a fixed or removable bridge or an artificial tooth called an implant.

CONSEQUENCES of not performing prescribed treatment include the risk of a serious infection, abscesses in the tissue and bone surrounding your teeth and eventually loss of the tooth.

COMMON RISKS specific to endodontic treatment and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which rarely is protracted and even more rarely is permanent. 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 canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. During or after the course of treatment, it is the patients' responsibility to report any abnormal symptoms to the endodontist immediately.

By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered satisfactorily.

PAYMENT FOR SERVICES RENDERED IS EXPECTED UPON COMPLETION OF TREATMENT. WE ACCEPT CASH, CHECK, OR CREDIT CARD. Because of the ever-increasing number of patients covered by dental insurance, the increased volume of paperwork, and the extended length of time required for payment from the insurance companies, we request that **ALL FEES ARE THE SOLE RESPONSIBILITY OF THE PATIENT and MUST BE PAID BY THEM**. We will gladly complete all forms and promptly submit them to the insurance carrier for reimbursement to the patient.

Parent/Patient Signature_____Date_____

☐ I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.