NORTHSIDE ENDODONTICS

Authorization and informed consent for endodontic therapy

I hereby authorize the endodontist to perform the following endodontic procedures:

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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: surgical procedures, or tooth removal. The advantages or disadvantages of each have been discussed. I have been advised that I may also choose to decline treatment at this time and understand the risks in not having treatment include, but are not limited to: pain, swelling, infections, increased bone loss, or loss of the tooth.

I also understand the following:

1. 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 required, or the tooth extracted.

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

3. It may be necessary to alter the tooth structure or remove the restoration of the tooth being treated.

4. Possible complications of treatment include, but are not limited to the following:
   a. Unusual circumstances which cannot be detected prior to beginning treatment, for example, blocked canal, calcified canal.
   b. Swelling, soreness, infection, muscle spasm, or discoloration of the adjacent soft or hard tissues.
   c. Fractures of the crown or root of the tooth or restoration.
   d. Fragmentation of root canal instruments during treatment.
   e. Perforation of the root with instruments.
   f. Complications following anesthesia (hematoma, paresthesia, allergy, increased heart rate, etc.)
   g. Complications following surgery (paresthesia, infection, swelling, bruising.)
   h. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.

   Treatment will be performed in accordance with generally accepted methods of endodontic practice. Included in the therapy will be the taking of a minimal number of x-rays as dictated by the course of treatment.

5. I have truthfully completed a history of my health and included any allergies I am aware of.

I certify that I have read fully and understand the above **GENERAL INFORMATION, FINANCIAL POLICIES, AND AUTHORIZATION AND INFORMED CONSENT** and that all of my questions were answered in a satisfactory manner.

Date: _____ Print Patient Name _____

_____ _____

Signature *(patient or legal guardian)* *(witness)*

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