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MUTUAL UNDERSTANDING/CONSENT FOR TREATMENT

I understand that root canal treatment is an attempt to save a tooth which otherwise requires extraction. Root canal therapy is needed to treat symptoms of infection or severe inflammation. Symptoms can include swelling and pressure tenderness and cold or hot sensitivity. Although root canal therapy has a very high degree of success, it is still a biological procedure. Teeth that are cracked or fractured have a lower success rate than teeth that have no fractures. 100% success cannot be guaranteed or warranted. Occasionally, a tooth that has a root canal may require retreatment, surgery or even extraction.

There are certain inherent and potential risks in any dental treatment or procedure. Alternatives to root canal treatment include tooth extraction and/or dental implant placement. I understand that the following may be potential risks of root canal treatment: numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is usually temporary but on rare occasions may be permanent; treatment failure; complications resulting from the risk of dental instruments (broken instruments, perforation of the tooth, root or sinus); and antibiotics may inhibit the effectiveness of birth control pills.

Because root canal therapy is a biologic procedure, swelling or discomfort may be experienced after treatment by some patients. It is difficult to predict which patient may or may not have swelling or discomfort. Prescriptions for pain management and/or antibiotics for infection will be provided if needed.

I will have an opportunity to ask questions and discuss with the doctor the nature of my treatment, the inherent risks of the treatment and the alternatives to this treatment.

I, the undersigned, consent to the treatment that will be mutually agreed upon to be advisable in the opinion of the doctor.

I also understand that only the root canal treatment will be done at Dr. Haidet, Dr. Susi and Dr. Stentz's office. The permanent (outside) restoration (filling and/or crown) will be done by my regular dentist within 2 to 3 weeks following the root canal treatment.

I also take full responsibility for the payment of such services and agree to pay for them in full, at or before the completion of treatment, unless other specific arrangements are made with this office.

I have read and understand this policy.

Signed: _____ **Date:** _____

(Signature of patient or responsible party)