NON-SURGICAL ENDODONTIC TREATMENT AND FINANCIAL CONSENT

1. Root canal therapy is treatment or retreatment performed to retain a tooth that might otherwise require extraction. Other treatment options include no treatment, waiting for more definitive symptoms to develop, or tooth extraction.

2. I understand the process of endodontic treatment requires taking x-rays, administering local anesthetic, placing a rubber dam, and performing the treatment itself: opening, cleaning, shaping, placing the permanent material called gutta percha, and a temporary filling. For the long-term success of this treatment, a permanent restoration is required.

3. During root canal therapy, certain procedural complications can occur. They include—but are not limited to— alteration of sensation (numbness), separated (broken) instruments, blocked/calcified canals, perforation of the crown and/or root that may or may not involve medicament(s) and/or solvents, and damage to restorations.

4. Treatment complications may be discovered which make treatment impossible or which require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, curved roots, periodontal (gum) disease, and splits/fractures of the teeth.

5. Local anesthetics will be used during root canal therapy. Some common side effects include pain, swelling, and bruising. Other rare side effects may include convulsions, weakness, allergic reactions, persistent numbness, stiffness in the jaw joint(s) or muscle (trismus), and injury to blood vessels.

6. Although root canal therapy has a high degree of success, it is still a biological procedure and, as such, cannot be guaranteed or warranted. Some teeth that have had root canal therapy may require retreatment, surgery, or even extraction.

7. I understand the root canal treatment performed in this office will be done by an *Endodontic Specialist* and the permanent restoration (filling, crown, etc.) will be done by my general (family) dentist.

8. Fees incurred for additional treatment by another dentist or physician is the responsibility of the patient.

9. Financial Agreement with Winter Springs Endodontics:

Tooth Number(s) & Treatment: _____ Estimated Fee: _____

Insurance or Discount Plan: _____ Estimated Co-Payment: _____

Patients with dental insurance will be responsible to pay the estimated insurance co-payment at the beginning of treatment and authorize the assignment of the insurance benefits to us. After insurance benefits are received, we will send a refund for any overpayment or a statement for any additional amount due. Unpaid balances older than sixty days are sent to collections. Any additional fees incurred by our practice to collect payment will be the responsibility of the patient, including but not limited to: check fees, bank fees, collection fees, court costs, attorney fees.

All my questions have been answered by the doctor and I understand the above statements. I hereby give my consent to the performance of endodontic therapy on the tooth or teeth listed above. I further give my consent to the administration of medications, anesthetics, drugs, and services deemed necessary to treat my endodontic problem. I attest the accuracy of the information provided on my health history form.

Patient Name Printed: _____

Patient/Parent Signature: _____ Date: _____