Endodontic Therapy Consent

Thank you for choosing Forest Hill Endodontics for your root canal needs and allowing us to be a part of your dental care.

Please read the following carefully:

It is required we obtain your signature prior to treatment, but it does not commit you to treatment. **The doctor and assistant will thoroughly explain the treatment process to you before beginning.**

I understand the root canal process is to retain a tooth that may otherwise need extraction. I understand that if my condition persists without treatment, my present oral condition will most likely worsen with time, the risks to my health may include but are not limited to: pain, swelling, infection, cyst formation, loss of supporting bone around teeth, and premature tooth loss. Although root canal therapy has a high rate of success, results cannot be guaranteed. A tooth which has had root canal treatment may require retreatment, surgery, or even extraction. However, this is not ordinarily the case. Teeth can remain sensitive for a week or two following treatment. Please let the office know if you experience this. Following treatment, a crown, and/or post and core may be necessary to restore the tooth to its normal function. Your **dentist** will be the one to do the final crown. During treatment there is possibility of paresthesia (numbness which may be temporary or permanent), trismus (lock jaw), exacerbation of TMJ issues, instrument separation within the tooth, perforations, damage to bridges, existing fillings, crowns, veneers, missed canals, loss of tooth structure in gaining access to inside of tooth, and fractured teeth. At times, a minor surgical procedure may be needed to properly treat the tooth or when a tooth may not be a candidate for traditional root canal treatment. Other choices are to have the tooth extracted or to do nothing at all. It is my responsibility as a patient to report any symptoms following treatment, any changes in my medical history or complications with medications prescribed to me by Dustin S. Reynolds, D.D.S., M.S. to the office immediately.

Please Print Name: _____

Signature: _____ **Date**: _____

(A Parent or Legal Guardian must sign for those under 18 years of age)

Privacy/HIPPA Notice

I have read the **Patient Privacy Notice** and understand how my medical/dental information may be used in accordance with my treatment.

Signature: _____ Date: _____