

# **AUTHORIZATION AND INFORMED CONSENT FOR ENDODONTIC THERAPY**

I (Patient's Name) \_\_\_\_\_ hereby authorize Dr. Welch and whomever he may designate as his assistant(s) to perform endodontic therapy as needed to treat my dental problem or condition. I further authorize the administration of medications and anesthetics, performance of diagnostic procedures, and such additional services that may be deemed and necessary, understanding that risks are involved.

Possible alternative methods of treatment may include the following: endodontic surgical procedures, tooth removal, or no treatment, and the advantages or disadvantages of each will be discussed. I understand that I may also choose to decline treatment at this time and understand the risks in not having treatment at this time and understand the risks in not having treatment include, but are not limited to, pain, swelling, infection, increased bone loss, and eventual tooth loss.

*I also understand the following:*

In general, over 90% of routine cases are successful. 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. In each instance, an additional charge will be made.

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

It is usually necessary to alter the tooth structure or remove the restoration (e.g. crown or filling) of the tooth being treated. Proper post-treatment restoration (filling, onlay, crown, etc.) is a necessity. I must contact my referring dentist soon after completion of the endodontic treatment to arrange for this.

Treatment will be performed in accordance with accepted methods of clinical practice. Included in the therapy will be the taking of a minimal number of radiographs (x-rays) as dictated by the requirements of the case.

Periodic recall examination is often recommended to evaluate the healing after treatment and no further charges are made for it. However, compliance is the responsibility of the patient.

Possible complications of treatment include, but are not limited to the following:

- procedural difficulties in the course of treatment.
- swelling, soreness, infection, trismus, paresthesia, or discoloration of the adjacent soft or hard tissues.
- fractures of the crown or root of the tooth or restoration.
- fragmentation of the root canal instruments during treatment.
- perforation of the root with instruments.
- complications following local anesthetic injection: hematoma, paresthesia, allergy, increased heart rate, etc
- additional unknown or unspecified problems, the explanation for and the responsibility of cannot be given or assumed.

A charge may be made for additional appointments resulting from the failure of the patient to follow the prescribed treatment schedule or for failing to show for an appointment without 48 hours notice. I understand that if payment is not made when due, the account may be turned over for collection. I will be responsible for any and all costs associated with the collection procedure, including but not limited to billing cost, collection fees, lawyers fees, and court costs.

I certify that I have read fully and understand the above authorization and informed consent and I am free to ask any questions pertinent to my treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian (if patient is a minor)