ENDODONTIC ASSOCIATES
EST 1964

Information and Consent for Endodontic (Root Canal) Treatment

Root canal therapy is performed to save a tooth that might otherwise require extraction. While treatment is usually successful, complications are possible. Please review this information carefully.

General Risks of Dental Care

- Swelling, bruising, or bleeding
- Temporary pain or sensitivity
- Numbness or tingling (usually temporary, but may be permanent)
- Reaction to injections
- Jaw stiffness, muscle soreness, or joint discomfort
- Changes in the way teeth fit together when biting
- Loosened teeth or referred pain to the ear, neck, or head
- Nausea or vomiting
- Allergic reactions
- Delayed healing or infection
- Sinus involvement
- Treatment failure

Patient/Guardian Initials: _____

Risks Specific to Root Canal Therapy

- Breakage of instruments within the canals
- Perforations (extra openings) in the crown or root
- Damage to existing crowns, bridges, veneers, or fillings
- Loss of tooth structure in order to access canals
- Cracked or fractured teeth
- Possible discovery of complications such as blocked canals, curved roots, gum disease, or hidden fractures

Patient/Guardian Initials: _____

Medications

- Some prescribed medications may cause drowsiness or reduced coordination.
- Alcohol, sedatives, or tranquilizers may increase side effects.
- Women taking birth control pills should use additional contraception if prescribed antibiotics.
- Inform your doctor of all medications (prescribed, over-the-counter, or supplements).
- Possible side effects of anesthetic include bruising, prolonged numbness, rapid heart rate, fainting, or allergic reaction.

Patient/Guardian Initials: _____

ENDODONTIC ASSOCIATES
EST 1964

Other Treatment Choices

- No treatment (risks: worsening infection, pain, swelling, tooth loss, spread of infection)
- Waiting for symptoms to worsen before treating
- Tooth extraction, with or without replacement (implant, bridge, denture)

Patient/Guardian Initials: _____

Consent

I consent to endodontic treatment and any necessary procedures the doctor deems advisable to complete my care safely and effectively. I understand root canal treatment attempts to save a tooth that may otherwise require extraction. Although root canal therapy has a high success rate, results cannot be guaranteed. A treated tooth may later require retreatment, corrective surgery, or extraction, which may involve additional fees. After treatment, I must return to my general dentist for a final restoration (filling or crown). Endodontic Associates will need to take their own x-rays and perform testing for accurate diagnosis.

Patient/Guardian Initials: _____

HIPAA

I acknowledge that the Notice of Privacy Practices is available and posted in the office lobby.

Patient/Guardian Initials: _____

Insurance & Financial Policy

- Co-payment is due at the start of treatment.
- Insurance estimates are not guarantees; I am responsible for any remaining balance after insurance payment.
- If Endodontic Associates does not file insurance on my behalf, payment in full is due at the time of service.
- If treatment cannot be completed because the tooth is non-restorable, a fee of $370 for incomplete treatment may apply.
- Endodontic Associates does not file worker's comp, medical, or accident insurance, but will provide documentation so I may submit a claim.

Patient/Guardian Initials: _____

Acknowledgment

By signing below, I acknowledge that I have read and understood this consent form, and I agree to proceed with treatment.

Patient Signature: _____ Date: _____

Parent/Legal Guardian (If patient is under 18): _____