Sheila Harris, D.D.S.

ENDODONTIC THERAPY INFORMED CONSENT

________ 1. I, THE UNDERSIGNED, VOLUNTARILY CONSENT to ________________________, his/her (or its) partners, associates, administrative team, dental assistants, and/or staff providing the endodontic (root canal) therapy which has been recommended.

________ 2. I accept and understand that endodontic therapy is an attempt to save a tooth or teeth that might otherwise require extraction. I also accept and understand that endodontic therapy is used to correct an apparent problem and occasionally undiagnosed and/or hidden problems arise.

________ 3. I have been fully informed that endodontic therapy is not always successful as the tooth or teeth is/are already in jeopardy.

________ 4. I accept and understand that this endodontic therapy will not prevent future decay and/or possible fracture. I also accept and understand that the endodontic therapy may not prevent future problem with the tooth or teeth, as the tooth or teeth will be more brittle.

________ 5. The endodontic therapy has been **fully explained to me** , including all risks and complications involved. I have been fully informed that the risks and complications may include, but are not exclusive of:

________ a. Perforation of the canal with instruments which could result in the loss of the tooth and perhaps surgery.

________ b. Nerve or sinus damage causing temporary or permanent numbness of the chin, tongue or lips.

________ c. Instrument breakage in the canal that may require surgery.

________ d. Minor pain.

________ e. Swelling.

________ f. Temporary or permanent numbness.

________ g. The need for additional treatment, surgery and/or extraction.

________ h. The need for additional procedures on the tooth or teeth, such as crown(s).

________ i. Loss of the tooth or teeth.

________ 6. I have been fully informed that the condition of the tooth or teeth will worsen and that other systemic problems could develop ***if the procedure is not done***.

________ 7. I accept and understand ***there is NO WARRANTY or GUARANTEE as to any result and/or cure***.

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_________ 8. I have had the opportunity **to discuss** the endodontic therapy, and have had an opportunity **to ask questions**, and am fully satisfied with the answers received.

_________ 9. If, during the endodontic therapy, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian):___________________________ Date: ______________

Patient's (or Parent/Guardian's) Identification: ____

Witness' Name: ____________________ Witness' Signature: _______________ Date:_________

Doctor's Signature: ______________________________________Date: ______________________

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