Denti-spa

10432 Reserve Drive Suite 110

San Diego CA 92127

INFORMED CONSENT FOR ROOT CANAL TREATMENT

(Patient's name) (tooth #)

I understand that root canal treatment is an attempt to save a tooth due to loss of vitality from infection, trauma, decay, or in restorative procedures, to attain sufficient retention or contour for a new crown. The procedure and its alternatives have been explained to me and I have been informed that occasionally there are complications concerning this treatment.

Possible risks and complications of this treatment include allergic reactions to medications or anesthetics, pain, swelling, and sensitivity to pressure or other discomfort during or after the root canal is sealed. Treatment may be modified or discontinued due to calcified canals, inaccessible canals, fracture of the roots or crown of the tooth, perforation, resorption, or instruments separated in the root.

I understand that in a few cases a surgical procedure may be indicated to seal otherwise inaccessible canals or to remove the infected apical portion of the root canal treatment.

The natural crown of the tooth may darken eventually and/or become brittle and may even fracture following the root canal treatment. Therefore, I understand the importance of having the tooth restored as soon as possible with a crown or a permanent filling.

Alternatives to root canal treatment are extraction of the tooth or no treatment. A root canal infection, left untreated, may cause serious symptomatic infection, which may endanger my health.

The dental care and treatment to be performed has been fully explained to me and I understand what is to be done. I have received a detailed explanation of all risks, benefits of and alternatives to the treatment. I have asked and received answers to all the questions I had regarding this treatment. I understand what is to be done and that there is no warranty of guarantee as to any result and /or cure. **Also, I understand that any necessary follow-up treatment cost (s) for complications resulting from root canal treatment are the responsibility of the patient.**

I have read and understand the terms and conditions of treatment. I consent to the root canal treatment, including the use of local or other anesthetics, and needed x-rays.

Patient's pf Authorized Signature Date

Witness's Signature