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CONSENT FOR ROOT CANAL TREATMENT AND EXPLANATION OF INSURANCE COVERAGE AND PAYMENT

Please review and sign the following consent. It does not, however, commit you to treatment.

This is my consent to the endodontic procedures as indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by the Endodontist and any assistants with whom he works. I agree to the use of local anesthesia. Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any of these symptoms to Endodontist immediately.

I understand that the root canal therapy is a procedure to retain a tooth, which may otherwise require extraction and that as a specialty practice; this office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. A restoration, such as a filling or crown and/or post and core will be necessary to restore the tooth to function – this will be performed by your general dentist.

During treatment there is the possibility of instrument separation within the root canals, perforations, damages to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amendable to endodontic treatment at all.

At times, medication will be prescribed by the Endodontist. I understand that medications for discomfort may cause drowsiness which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of the reactions occur, I am to call Dr. Isaac immediately. I understand that is my responsibility to report any changes in my medical history.

I understand that the total payment of the dental service is my responsibility and NOT that of the insurance company. We will assist you in completing any insurance forms, so that you may be reimbursed by your insurance company. The Endodontist fees may not be covered or may exceed your plan benefits. Examination/consultation fee is $150. The consultation fee will not be waived or applied toward the cost of treatment. Fees for treatment vary per tooth and per procedure. Payment is due when services are rendered. We accept Visa, MasterCard, Debit and Cash.

I fully understand the above statements in this consent.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Tooth #	Type of procedure