WEST SEATTLE ENDODONTICS
5016 California Ave. #101 Seattle, WA 98136

CONSENT FOR ENDODONTIC TREATMENT

Patient's Name: _____

Date: _____

Proposed Treatment:

Root canal treatment includes opening up a tooth through the biting surface, cleaning out bacteria and debris, and then filling the root canal space. Root canal treatment is known to be highly successful, but success cannot be guaranteed. Usually, the alternative to root canal treatment is removing the tooth. Occasionally, despite all efforts, the tooth may require retreatment, surgery, or extraction.

Root canal therapy is performed to save the tooth. I understand that my alternative treatment options include: no treatment or extraction (pulled). If the tooth is extracted, I understand that this tooth may be replaced by an implant, bridge, or partial denture.

I have been informed of the need for the root canal services listed above and understand the possible complications of any treatment rendered, including breakage of a metal instrument in the tooth, overextension of the filling material beyond the end of the root, blocked or calcified canals, perforation of the crown or root into the jawbone, tooth fracture, temporary or permanent numbness, pain, and infection. If the tooth is covered by a crown, I understand that a hole must be drilled through the crown or adjacent teeth/crowns may be damaged in the process, requiring a new crown or repair. I understand the possible consequences of not receiving treatment in the near future, including risk of infection, pain, and the possible loss of the tooth.

I have been informed why it is important to have a "permanent" filling placed in, or a crown (cap) placed over the tooth reasonably soon after a root canal treatment is completed. Failure to have the tooth restored in this manner could result in contamination of the root canal and failure of the root canal treatment, possibly leading to the loss of the tooth. I will have to seek private care to have the tooth restored. After the root canal treatment is completed, a **temporary filling** will be used to seal up the tooth and it will be necessary to seek a "permanent" filling or crown from a restorative dentist.

I agree to pay the stated fees in effect at the time of treatment rendered and to present myself, or a minor child, for treatment as discussed. I have had an opportunity to ask questions about the proposed treatment and have had them answered to my satisfaction. I have read, understand, and now give my permission for diagnostic and treatment services for myself or my minor child named above.

Patient name (print): _____

Patient (or Parent / Guardian) signature: _____

Date: _____