



CONSENT FOR ENDODONTIC TREATMENT

I hereby authorize Dr. Corden / Dr. Davenport / Dr. Hulyiar / Dr. Kaplan / Dr. Patel and any other agents or employees of Advanced Endodontics of Chicago to treat the condition(s) described below:

1. The procedure(s) necessary to treat the condition(s) has been explained to me, and I understand the nature of the procedure to be:

a) Non-surgical root canal therapy on tooth number(s) _____

b) Non-surgical root canal re-treatment on tooth number(s) _____

c) Other

2. I have been informed of possible alternative methods of treatment including no treatment at all and extraction.

3. Root canal success rates are about 93-97% based on current scientific literature. Leaving approximately 3-7% of cases that may not respond to treatment or warrant further treatment.

4. My treating doctor and the staff of Advanced Endodontics of Chicago have provided me with answers to all of my questions concerning the nature of treatment; the inherent risks; and the alternatives to this treatment.

Please read each item:

5. The possibility of a fractured or cracked tooth may lead to pretreatment or post treatment symptoms. I understand that the extent of a crack or fracture often cannot be determined prior to root canal treatment. This may lead to treatment failure and the need to extract the treated tooth.

6. I understand that upon completion of root canal therapy, I must schedule with my general dentist for the final filling or crown within four (4) weeks. Failure to schedule the restoration in a timely fashion may lead to the need for further treatment, at which point I will be responsible for any associated fees.

7. I understand that the payment is due in full at the time of service, OR if I have dental insurance, I will remit the amount provided to me by the insurance coordinator.

8. Instruments used today to clean & amp; shape the inside of your tooth have greatly improved our ability to do root canal therapy. However, these instruments occasionally separate. This very rarely causes any negative outcomes however may lead to the need for additional treatment.

9. If root canal therapy has to be complete through the crown, there is a risk the crown may break, fracture, or become decemented.



All of the foregoing has been explained to me. I understand the information that has been provided to me and my signature below indicates that I consent to the recommended treatment.

Patient Signature: _____ Date: _____

Print Name: _____