ENDODONTIC ASSOCIATES, INC.

OUR POLICY OF INFORMATION AND HONESTY TO OUR PATIENTS
PATIENT CONSENT FOR ENDODONTIC TREATMENT

Our communication to our patients is very important. Your understanding of your dental condition, treatments, options and alternatives given by our dental specialists and the reason for your referral to our office(s) will help in our communication effort. In this day and age honesty is the best policy. The following is a comprehensive disclosure that you need to be aware of. It is not meant to alarm you.

DISCLOSURE: There are inherent and potential risks in any dental treatment or procedure such as swelling; sensitivity; bleeding; pain; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (bite); jaw muscle cramps and spasm; TMJ difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing beyond control by the doctor; sinus perforations; treatment failure; complications resulting from the use of dental instruments (potential broken instruments, files, perforation of tooth and sinus), medications, anesthetics and injections; discoloration of the teeth, and face; reactions to medications causing drowsiness and lack of coordination; and antibiotics which may inhibit the effectiveness of birth control pills.

I understand that a perfect result can not be guaranteed or warranted and that endodontic procedures are an attempt to relieve pain, swelling, sensitivity, soreness and infection in order to maintain my tooth (teeth) and occlusion. In some instances it is preventative and proactive in nature. I have been given the opportunity to ask questions concerning any aspect of my care and treatment plan. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

Despite the information given above, you should keep two very important points in mind. As dental specialists we see the most complicated and challenging dental problems. And in spite of these challenges and realities our success rates remain very high. It is our sincere hope to provide care to you in a comfortable and compassionate manner with every effort given to help you maintain function of your teeth and viability of your smile.

I hereby authorize and give my consent to the dental specialists of Endodontic Associates, Inc. to render my dental care.

(Patient Signature) _____(Date)_____

(Doctor Signature)_____(Date)_____