CONSENT FOR ENDODONTIC THERAPY Patient Name_____
Tooth # _____

Please read and then initial each paragraph when you understand the contents.

1. I hereby give my consent for **Stephen P. Pryor, D.D.S**. to perform root canal treatment of the tooth or teeth listed.
2. I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction.
3. I understand that root canal treatment can have a very high degree of clinical success (85-95% of the routine cases are successful), however, as with any branch of medicine or dentistry, no guarantee of successful treatment can be given or implied. Occasionally, a tooth which has had a root canal treatment may require retreatment, a surgical procedure, or even extraction. Root canal cases started in other offices or retreatment cases may have a lower success rate even when the procedure is carried out under optimal conditions.
4. I understand that to accomplish the root canal procedure it is necessary to alter the existing tooth structure and/or restorations. These alterations require the placement of a new restoration or crown following endodontic therapy. I also understand that proper restoration of the tooth after root canal treatment is a necessity. A crown is generally recommended following root canal treatment to protect the tooth from fracturing. The fee for endodontic treatment does not include these restorative procedures. In addition, I understand it is the patient's responsibility to contact his/her dentist to schedule an appointment to have an appropriate restoration placed following the root canal procedure.
5. I understand that a periodic recall examination of the tooth, to include radiographs, is recommended to evaluate the success of the treatment rendered. We offer the follow up examination at no charge every year and as needed, however compliance is the patient's responsibility.
6. Treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and placement of a rubber dam. In addition, a number of radiographs will be necessary to accomplish the root canal procedure. The number of radiographs required will vary with the complexity of the case.
7. Possible complications of treatment include, but are not limited to:
    - Curved canals/roots
    - Calcification in the root canal space
    - Procedural difficulties such as the separation of instruments in the root canal space, and perforation of the crown or root while looking for the canal space
    - Fracture of the crown or root
    - Infection, swelling, or discoloration of the adjacent tissues
    - Pain during or following treatment
8. I understand that I am free to withdraw my consent and discontinue treatment at any time; however, complications such as bone destruction, infection and swelling, and/or pain, etc, may predictably occur if I retain the tooth and the root canal treatment is not completed.
9. The number of treatment visits required to complete the root canal varies with the complexity of each case. Generally, the routine cases can be completed in one or two appointments.
10. If at anytime I have questions about the treatment I am receiving, they will be promptly answered.

Estimated Fees $_____
Patient or legal Designate_____ Date Signed_____
Witness_____ Date Signed_____