PROVIDENCE
ENDODONTICS

Informed Consent

This is giving my consent to the endodontic procedures indicated and any procedures deemed necessary and advisable as a corollary to the planned endodontic therapy performed by any of the endodontists; Dr. Jessica Kim, Dr. Meetu Kohli, Dr. Nadia Gharbi, Dr. Melanie Martel, Dr. Nora Paisner, Dr. Veronika Sokolovski and any assistance they may require. I agree to the use of local anesthesia, sedation and/or analgesia, depending on the judgment of the endodontist involved in my case. Complications of root canal therapy and anesthesia may include swelling, discomfort, 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 root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, results can not be guaranteed. Occasionally a tooth which has had root canal therapy may require re-treatment, surgery, or even extraction**. I understand that only the root canal therapy is performed in this office; restoration of my tooth (filling, crown, etc,) will be done by my family dentist.** During treatment there is a possibility of instrument breakage within root canals, perforations (extra openings) damage to bridges, existing fillings, crowns, porcelain veneers, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated when my tooth may not be amendable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definite symptoms to develop or tooth extraction. Risks involved in these choices may include but are not limited to pain, infection, swelling, loss of teeth and infection to other areas.

I understand that medication for discomfort and sedation may cause drowsiness which can be increased with the use of alcohol or other drugs. I will avoid 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 these reactions occur, I am to call the doctor immediately. I understand that is my responsibility to report any changes in my medical history.

All responsible collection and/or legal costs required to collect fees due **Providence Endodontics**, will be borne by the undersigned.

ALL SIGNATURES MUST BE BY A PARENT OR GUARDIAN IF PATIENT IS 18 YEARS OLD OR YOUNGER.

PRINT NAME _____

SIGNATURE _____

DOCTOR'S SIGNATURE _____TREATMENT _____