Crown Dental Studio

CONSENT FOR ROOT CANAL TREATMENT

I (Patient name) _____

hereby authorize Crown Dental Studio / any associates to perform a root canal on tooth/teeth number(s): _____

The doctor has explained to me that the purpose of this procedure is to retain teeth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand that this is an elective procedure and that there are alternative treatments, and the doctor has explained the risks and benefits of the alternatives. I also understand that root canal therapy has a very high success rate, but the doctor has not guaranteed or warranted a perfect result. The doctor has explained to me that there are certain potential risks in the procedure. These include:

1. Inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth);

2. Infection that may occur and may continue, requiring further endodontic surgery or extraction;

3. Fracture or breakage of the root or crown portion during or after treatment;

4. Inadvertent breakage of files or instruments within the root canal system that are unable to be retrieved;

5. Perforation of the tooth or root of the tooth during treatment;

6. Damage to existing fillings, crowns or porcelain veneers;

7. As a result of the injection or use of anaesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues.

Unforeseen conditions may arise that require a procedure that is different than set forth above, a repeat treatment, or I might be referred to a specialist for further treatment. I authorize CROWN DENTAL STUDIO and any associates to perform such procedures when, in their professional judgment, the procedures are necessary, after discussing the option with me, and obtaining my consent (except in emergent circumstances where consent might not be practical to obtain).

Crown Dental Studio

I understand that the medications, drugs, anaesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that drugs and anaesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle or machinery until I have fully recovered from the effects of the medications.

I UNDERSTAND THAT TREATMENT OF DENTAL CONDITIONS REQUIRING ROOT CANAL TREATMENT INCLUDES CERTAIN RISKS AND POSSIBLE UNSUCCESSFUL RESULTS, INCLUDING THE POSSIBILITY OF FAILURE. EVEN THOUGH CARE AND DILIGENCE IS EXERCISED THERE ARE NO PROMISES OR GUARANTEES OF ANTICIPATED RESULTS OR THE LONGEVITY OF THE TREATMENT. I CONFIRM THAT CROWN DENTAL STUDIO OR ANY OF ITS AFFILIATES SHALL NOT BE HELD LIABLE FOR ANY UNSUCCESSFUL RESULTS.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

I HEREBY CONSENT AND AGREE TO RECEIVE THE FOLLOWING ALTERNATE TREATMENTS IN THE EVENT OF THE DESIRED RESULTS NOT BEING ACHIEVED:

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____
4. _____
   _____
   _____
5. _____
   _____
   _____

Crown Dental Studio

PATIENT PARTICULARS:

FULL LEGAL NAME: _____

IDENTITY NUMBER: _____

ADDRESS: _____

_____

_____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

Accepted and Signed at _____ on this _____ day of _____ 20_____

in the presence of the undersigned witnesses

_____

PATIENT NAME:
IDENTITY NUMBER:
CONTACT NUMBER:
EMAIL ADDRESS:

Witnesses:

1. _____
   NAME:
   CONTACT NUMBER:
2. _____
   NAME:
   CONTACT NUMBER: