Goehring Dental
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Informed Consent for Root Canal Therapy

I (we) voluntarily request that Dr. Goehring/Badea as my dentist, and any technical assistants, to perform root canal treatment on tooth #_____

Please initial each of the following paragraphs:

_____ I understand root canal treatment is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require re-treatment, surgery or even extraction and I will be referred to a specialist if necessary for re-evaluation.

_____Although rare, the following complications may occur in endodontic therapy:

1. Pain and swelling 5%
2. Damage to existing filling or crown ½%
3. Fracture of a root 1%
4. Overfill or under fill or perforation of a root less than 5%
5. Broken instrument left in a canal less than 1%

_____ I understand that after a root canal is finished a permanent restoration (post and core, buildup and crown, fillings, etc.) should be done to restore the tooth properly and protect it from breaking.

_____ I also understand the final restoration (buildup and crown) is not included in the charges for the root canal treatment, and will require separate financial arrangements.

_____I accept full responsibility for the payment of services performed and agree to pay for them in full, at or before completion, unless other specific arrangements are made with the receptionist.

_____I understand that antibiotics reduce the effectiveness of some oral contraceptive drugs, (birth control pills). I have been advised to use additional forms of contraception while taking antibiotics until I can consult with my own physician.

I have read and fully understand this consent for endodontic treatment.

_____ _____
Patient, Parent or Guardian Date

_____ _____
Witness Date

_____ _____
Doctor Date