

**ENDODONTIC THERAPY  
INFORMED CONSENT**

- \_\_\_\_\_ 1. I, THE UNDERSIGNED, VOLUNTARILY CONSENT to Dr. Goldenberg, his partners, associates, administrative team, dental assistants, and/or staff providing the endodontic (root canal) therapy which has been recommended.
- \_\_\_\_\_ 2. I accept and understand that endodontic therapy is an attempt to save a tooth or teeth that might otherwise require extraction. I also accept and understand that endodontic therapy is used to correct an apparent problem and occasionally undiagnosed and/or hidden problems arise.
- \_\_\_\_\_ 3. I have been fully informed that endodontic therapy is not always successful as the tooth or teeth is/are already in jeopardy.
- \_\_\_\_\_ 4. I accept and understand that this endodontic therapy will not prevent future decay and/or possible fracture. I also accept and understand that the endodontic therapy may not prevent future problem with the tooth or teeth, as the tooth or teeth will be more brittle.
- \_\_\_\_\_ 5. The endodontic therapy has been **fully explained to me**, including all risks and complications involved. I have been fully informed that the risks and complications may include, but are not exclusive of:
- \_\_\_\_\_ a. Perforation of the canal with instruments which could result in the loss of the tooth and perhaps surgery.
  - \_\_\_\_\_ b. Nerve or sinus damage causing temporary or permanent numbness of the chin, tongue or lips.
  - \_\_\_\_\_ c. Instrument breakage in the canal that may require surgery.
  - \_\_\_\_\_ d. Minor pain.
  - \_\_\_\_\_ e. Swelling.
  - \_\_\_\_\_ f. Temporary or permanent numbness.
  - \_\_\_\_\_ g. The need for additional treatment, surgery and/or extraction.
  - \_\_\_\_\_ h. The need for additional procedures on the tooth or teeth, such as crown(s).
  - \_\_\_\_\_ i. Loss of the tooth or teeth.
- \_\_\_\_\_ 6. I have been fully informed that the condition of the tooth or teeth will worsen and that other systemic problems could develop ***if the procedure is not done.***
- \_\_\_\_\_ 7. I accept and understand ***there is NO WARRANTY or GUARANTEE as to any result and/or cure.***
- \_\_\_\_\_ 8. I have had the opportunity **to discuss** the endodontic therapy, and have had an opportunity **to ask questions.** and am fully satisfied with the answers received.
- \_\_\_\_\_ 9. I accept and understand that I have the right to seek endodontic treatment from a American Dental Association-recognized specialist in endodontics.
- \_\_\_\_\_ 10. If, during the endodontic therapy, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_