

Patient Consent to Treatment

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

(Initials) _____

(Please Print Name) _____

Endodontic Treatment (Root Canal Therapy)

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by replacement of a crown (cap) over the tooth.

I understand that treatment risks can include, but are not limited to the following:

- A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
- B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
- C. Infection.
- D. Restricted jaw opening.
- E. Breakage or root canal instruments during treatment, which may in the judgment of the doctor be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
- F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
- G. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(Initials) _____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.



I UNDERSTAND THAT MASCOT DENTAL CENTRE PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOUR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DIABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

SIGNATURE: _____
PATIENT/PARENT/GUARDIAN

DATE: _____

DENTIST

WITNESS

Please feel free to contact your Dentist at any stage if you have questions.