



Informed Consent for Root Canal Treatment

Root canal treatment is a procedure to retain a tooth that may otherwise require extraction. It involves cleaning, shaping and filling the tooth's pulp space. Root canal treatment has a success rate of approximately 90%; however, no guarantee of success can be given or implied. A tooth that has had a root canal may require retreatment, a surgical procedure or extraction.

To accomplish a root canal procedure, it is necessary to alter the existing tooth structure and/or restorations. This requires the placement of a new restoration or crown following endodontic therapy. Please call your general dentist as soon as possible after your root canal to schedule a permanent restoration. Neglecting to have a permanent restoration could lead to failure of your new root canal and the loss of your tooth.

Possible complications of treatment include but are not limited to the following:

- Pain, swelling, bruising, infection, prolonged bleeding
- Temporary or permanent numbness
- Inability to fully treat the tooth due to various limitations (curved and calcified roots for example) among other complications that include overfilling of the root, root perforation, TMD—problems with the jaw joint and small instruments breaking in the canal which must be left in place
- Fracture and/or dislodgement of the crown and/or vertical root fracture
- Continued pain and infection that may require further endodontic treatment or extraction
- Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed

Medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and a lack of cognitive ability. These substances may cause unanticipated reactions that may require medical treatment. Alcohol and other drugs can increase these effects. Prescribed medications should be taken as directed—these medications are incompatible with driving and/or working with machinery.

I have been given the opportunity to ask questions about my treatment and am fully satisfied with the answers received. I have been told I need a permanent restoration. I understand that I am free to withdraw my consent and discontinue treatment at any time; however, complications such as bone destruction, infection, swelling, and/or pain among other issues may occur if the root canal is not completed and the tooth restored. Knowing that these risks exist and that they might happen to me, I consent to allow Dr. Mounce to perform the recommended root canal treatment.

Financial Policy

Dental Insurance: For those patients who are insured, our staff will assist you in obtaining the maximum benefits under the terms of your policy. The information we are given by your insurance carrier is not a guarantee of benefits or payment. Your coverage is limited to the terms of your policy. Your insurance policy is an agreement between you and your insurance company. You are responsible for all charges, not your insurance company. We are not participating providers with any insurance company except Delta Dental.

For insured patients, at the time of service we collect a minimum of \$50 for consultations and a minimum of 1/3 of the total bill as a deposit. After the insurance company pays our office, we will either send you a bill or a refund depending on the resulting balance. You are responsible for payment in full of any remaining charges after your insurance company has paid.

Payment options and additional information:

- All patients are eligible for a 5% discount for payment in full at time of service.
- We accept Visa and Master Card.
- A 1.5% monthly finance charge will be added to any outstanding account balance after 30 days.
- Accounts that receive no payment for 60 days will be sent to a collection agency.
- Our fee does not include the permanent filling or crown to be done by your general dentist.
- Returned checks are charged at \$30.00 per check.

With my signature below, I acknowledge receipt of the Informed Consent for Root Canal Treatment and Financial Policy.

Signature (patient / guardian): _____ Date: _____