

I, (print name) _____, hereby authorize

Dr. Chahine at Dental Wellness and Health to perform root canal treatment on the following tooth (teeth):

The nature and purpose of root canal treatment, including the possibility of infection which could become systemic in nature, and possible alternative methods of treatment including extraction have been explained to me, and I fully understand them.

I understand that during the treatment I may have periods of discomfort and swelling. I further understand that many factors contribute to the success of root canal treatment and cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of the factors which may lead to an untoward result are: my resistance to infection, fracture of the tooth prior to completion of the root canal procedure and or before the definitive restorative procedure, the separation of an instrument, the perforation of the root, and the location and shape of the canals, etc.

I have been informed that should the treatment have to be discontinued before completion, or if it fails following treatment, other procedures may be necessary to save the tooth, including but not limited to, retreatment or apicoectomy. If endodontic surgery is necessary, I will be referred to an appropriate specialist.

I understand that it is my responsibility to have the tooth restored as recommended by the doctor upon completion of endodontic treatment.

I further understand that during and following the treatment, I must follow all home care instructions, and I am to contact the doctor's office if I have any additional questions, or I experience any unexpected reactions.

In case of an acute emergency and in the event I cannot reach this office or we have not returned my call in a reasonable amount of time, I should proceed to the nearest emergency room for medical attention.

I acknowledge that no guarantees or assurances have been given by anyone. Alternative treatment plans have been fully explained to me along with possible outcomes and risks.

I have been given ample time to discuss the procedure with the doctor and have had all of my questions and concerns answered to my satisfaction

Patient's Signature (Or Guardian if a Minor)

Doctor's Signature

Witness's Signature

Date