CONSENT FOR TREATMENT

REASONS FOR TREATMENT: Endodontic (root canal) therapy is accomplished in an effort to save a tooth which otherwise would require extraction. Treatment is done by standard root canal therapy, or when necessary, endodontic surgery.

RISKS SPECIFIC TO ENDODONTIC THERAPY: Those risks include the possibility of instruments broken within the root canals, perforations, damage to crowns or the root of the tooth, damage to existing bridges, fillings or crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require endodontic surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, splints or fractures of the teeth.

OTHER RISKS OF TREATMENT: Included (but not limited to) are complications resulting from the use of instruments, drugs, sedation, medicines, analgesics (painkillers), anesthetics and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient, but on rare occasions may be permanent, reaction to injections, changes in occlusion (the bite), jaw muscle cramps and spasms, temporomandibular (TMJ) difficulty, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any motor vehicle or hazardous device until recovered from their effects. IN THE EVENT YOU NEGLECT TO INFORM US OF NARCOTICS YOU ARE TAKING BY ANOTHER DOCTOR SERIOUS ACTION MAY BE TAKEN.

CONSENT: I, the undersigned, being the patient (parent or guardian of a minor patient) consent to the evaluation and or procedures deemed advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I NEED TO RETURN TO MY REFERRING and/or REGULAR DENTIST for a permanent restoration of the tooth involved. I understand that root canal treatment is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require additional treatment, such as, surgery or even extraction.

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PATIENT or PARENT/GUARDIAN SIGNATURE DATE

OFFICE FINANCIAL POLICY

PAYMENT IN FULL IS REQUIRED AT THE TIME SERVICES ARE RENDERED

For your Convenience Visa, MasterCard, Discover, American Express, Care Credit, Cash or Personal Check are accepted forms of payment.

ANY RETURNED CHECKS WILL INCUR A FEE UP TO $40.00, AND WILL BE SUBJECT TO BE REFERRED TO THE STATES ATTORNEY OFFICE BAD CHECK DIVISION. (Any legal fees and fines will be the patient's responsibility.) I have read your financial policy and am aware payment is expected today. I intend to pay with ___cash___check___credit card___care credit financing.

CANCELLATIONS OR FAILED APPOINTMENTS

I agree that if I am unable to keep my appointment I will contact Bay Area Endodontics at least 24 hours prior to my scheduled appointment time to reschedule**. I understand that a fee of $75.00 will be charged to my account if I fail to give any notice or less than 24 hours.**

I agree and understand that I may be charged 1.5% interest rate per month administration fees on any unpaid balance, and that I am responsible for any costs incurred in collection of the said balance should that become necessary. I have read and understand the above and agree to comply.

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PATIENT OR GUARDIAN SIGNATURE DATE