Authorization and Informed Consent for Endodontic Therapy and Medications

I hereby authorize Dr. Goodis, to perform Endodontic therapy and allow whomever he may designate to be his assistant.

I further authorize the administration of medications and anesthetics, performance of diagnostic procedures and such services that may be deemed reasonable and necessary.

Possible alternative methods of treatment may include surgical procedures, tooth removal, placing an implant, partial denture, or fixed bridge. I realize that I may also choose to decline treatment at this time. I understand the risks in not having treatment include, but are not limited to: pain, swelling, infection, increased bone loss or loss of the tooth.

I also understand the following:

As a rule, 90-95% of routine cases are successful. No guarantee of treatment success can be given or implied. I understand that many factors contribute to the success of root canal treatment which 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 these factors are of the following: my resistance to infection, the location and shape of the canals, cracked root, poor periodontal health of the tooth, or not having the tooth promptly restored by my (a) general dentist (for example not having a crown placed on the tooth when indicated after having root canal treatment).

1. If treatment is not successful, surgery (Apicoectomy) or extraction of the tooth may be required at an additional cost.

2. Cases started in other offices or re-treatment cases are usually more difficult and may have a different outcome than expected under optimal conditions.

3. It may be necessary to alter the tooth structure or remove the filling or crown from the tooth being treated.

4. Some cases may require a second or multiple visits to complete Endodontic Treatment.

5. Possible complications of treatment include, but are not limited to the following:
   a) swelling, soreness, infection, trismus (difficulty in opening the mouth) or discoloration of the adjacent soft tissues.
   b) fragmentation of Biocompatible instruments inside the root. (Rarely occurs)
   c) perforation of the root. (Rarely occurs)
   d) complications following anesthesia (bruising, swelling, allergy, increased heart rate, etc.).

6. Proper post-treatment restoration (filling, onlay, crown, etc.) is a necessity. I must contact my referring dentist soon after completion of the Endodontics to arrange for this. I understand that my general dentist will charge me an additional fee for this procedure.

Treatment will be performed in accordance with accepted methods of practice. Included in the therapy will be the taking of x-ray films (4-6) as dictated by the courses of treatment.

I certify that I have fully read and understand the above authorization and informed consent.

_____/_____/_____ _____

Date Signature of patient or legal guardian