HOLDBROOK DENTAL

INFORMED CONSENT FOR ENDODONTIC TREATMENT

Dr. Gerard Corsi Jr. DMD has explained the benefits and risks of endodontic treatment on tooth #(s) _____ to me. I understand that the endodontic treatment involves the removal of tissues in the center of the tooth (root canal) and the sealing of the space that is created during the process of removal and cleansing of the root canal system. I further understand that the root canal treatment may fail if proper restoration of the tooth is not completed after the root canal treatment is done, and that such restoration is a separate and distinct procedure with an additional fee.

I understand and accept the treatment recommended for me by Dr. Gerard Corsi Jr. DMD. I further understand that there may be some unwanted complications, some of which are listed below. No guarantees have been made or implied. Alternative treatment(s) and the option of no treatment have been explained to me. I understand that an alternative treatment may include extraction of the involved tooth or teeth. I understand the risks of no treatment include, but are not limited to infection, swelling, cyst formation, pain, loss of tooth/teeth and/or systemic disease. All of my questions have been addressed.

Proposed fees have been explained to me, as have any third party insurance benefits. I understand that third party benefits may be different than discussed by Dr. Gerard Corsi DMD as they are not under the control of this office.

Treatment risks/unwanted consequences may be (but are not limited to):

- Root fracture/crown fracture
- Potential for treatment of root canal or possible surgical treatment
- Recurrent decay
- Temporary or permanent numbness or tingling of the lip, chin, tongue or other areas
- Post treatment swelling and/or pain
- Post treatment infection
- Reaction to medications/anesthetic
- Color of the tooth may change (become darker than adjacent teeth)
- Instrument breakage in the tooth/perforation of the root(s)

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN TO ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient Name (Please Print) _____

Patient/Legal Representative Signature _____ **Date** _____

Witness _____ **Date** _____