Nivine Y. El-Refai, BDS, DDS, MSD, Inc.
Practice Limited to Endodontics & Periradicular Surgery

CONSENT FOR ENDODONTIC TREATMENT

I, the undersigned, consent to receive special consultation and should I agree to accept professional advice, also consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor.

I have been informed of possible alternative methods of treatment including no treatment at all. I have also been given an opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment and the alternatives to this treatment.

I understand the goal of endodontic root canal treatment is to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of clinical success, it is a dental-biological procedure whose results cannot be guaranteed. Occasionally a tooth, which has had root canal treatment, may require retreatment , surgery, or even extraction. I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at or before COMPLETION, unless other specific arrangements are made with the secretary.

Signed: Patient or Parent ________________________________ Date ________

Witness: ____________________________

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