

Bingham Endodontics; Val H. Bingham DDS, MS

CONSENT FOR ENDODONTIC TREATMENT

Patient Name: _____ **Tooth#** _____

HIPAA – Privacy Practices Acknowledgement

I am aware of the Notice of Privacy Practices, I was provided an opportunity to review it.

Endodontic Treatment, as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of success can be given or implied. As a rule, 90% of routine nonsurgical cases are successful.

I understand there are alternative methods of treatment including no treatment.

Cases started by other dentists or retreatment cases may have a different outcome than expected under optimal conditions.

Following your root canal treatment a permanent restoration must be done. **I understand I must make an appointment with my General Dentist to arrange for final restoration.** Temporary restorations can begin to wash out and leak **within one month** and lead to failure of the root canal.

During root canal treatment it may be necessary to alter the tooth structure or the restoration on the tooth being treated. In some cases, the dentist may remove the existing crowns, bridgework, or restoration.

Possible complications of treatment include, but are not limited to:

- Procedural difficulties in the course of treatment (separated instrument, perforation, overfilling, underfilling, etc.)
- Fracture of the crown, root, or entire tooth
- Swelling, pain or discoloration of the soft or hard adjacent tissues
- Persistent numbness
- Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed
- Post-treatment infection

Treatment will be performed in accordance with accepted methods of clinical practice. Included in the therapy will be the taking of a minimal number of x-rays as dictated by the course of treatment.

Payment is due at the time of service. For patients with dental insurance a claim will be filed on their behalf. Finance charges are assessed 30 days after the insurance pays on any unpaid balance.

Your signature on the consent form authorizes insurance payments be sent directly to Val H. Bingham DDS, MS.

I read and understand the above statements regarding my care at Bingham Endodontics

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____