CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

Occasionally, Dr. Lo will prescribe medication. Medication prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you DO NOT operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call Dr. Lo immediately. It is the patient’s responsibility to report any changes in his/her medical history to Dr. Lo.

I understand that root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated endodontic surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which had had a root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured tooth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involve in those choices might include, but are not limited to, pain, infection, swelling, loss of tooth, and infection to other areas.

Dr. Jeffrey M. Lo has answered all of my questions, and I fully understand the above statements in this consent form.

Furthermore, I give Dr. Jeffrey M. Lo my permission to voice record, tape digitally, videotape and/or take 35mm and/or digital photos of any procedure for purposes of completing my medical record and/or for patient education.

NOTE: All medical records will be kept strictly confidential.

Patient (Print Name) ________________________________

Patient (Signature) ________________________________

Date ________________________________

(If patient is under the age of 18, the signature of a parent or guardian is required)