Dr. Gregory K. An
Dr. Jean A. Yang

INFORMED CONSENT FOR EVALUATION AND ROOT CANAL TREATMENT

We are concerned not only about your dental health and endodontic treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our commitment to you is to provide you with detailed and complete information about your dental needs as we diagnose them. We will share our diagnostic processes with you, and we invite and welcome all of your questions regarding our work with you.

Towards this aim of a full, mutual sharing of information we feel it is important to advise you of the reasonable risks of endodontic therapy. The following is important information you need to have in making your decision about treatment:

- Root canal therapy is a procedure designed to retain a tooth, which may otherwise require extraction. Root canal therapy has a very high degree of success. However, it is a biological procedure and results cannot be guaranteed.

- Occasionally, and despite our best efforts, a tooth that has undergone non-surgical root canal therapy may require re-treatment or root canal surgery.

- We make special efforts to preserve the crowns of teeth we treat, but despite our best efforts occasionally a porcelain crown may fracture and require a new restoration. Even after root canal therapy, approximately 5% of endodontically treated teeth may eventually require extraction.

- Final restoration (crown) of the tooth that has undergone root canal therapy is essential for retention of the tooth. A final restoration should be completed within 30 days of root canal therapy. Final restorations are provided by your restorative dentist.

Also, our Office policy is to collect the fees that the patient is responsible for IN FULL on the day of service. After the insurance claim has been processed any remaining balance is the patient's responsibility. The following is the credit card to be kept on file for these balances.

Credit Card _____ **Account Number** _____

Expiration Date _____ **Security Code** _____

Authorized Signature _____

_____ **Date** _____

Signature of Patient (or Parent)

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature **Date**