ENDODONTIC SPECIALISTS
INFORMED CONSENT for ENDODONTIC (ROOT CANAL) THERAPY

The doctors and staff of Endodontic Specialists would like to inform you about commonly occurring risks of root canal treatment and alternatives for treatment. Endodontic (root canal) therapy is performed in order to save teeth which otherwise might need to be extracted. If no treatment is rendered, present conditions may worsen or remain the same. Despite a high degree of clinical success, there are no guarantees that teeth will be saved or symptoms will resolve. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

RISKS Can include (but are not limited to); pain, swelling, infection, reaction to medication or anesthetics, changes in occlusion (biting), delayed healing, the need for further treatment and tooth loss. Less frequent complications are; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is usually temporary but can be permanent, loss of taste, jaw muscle cramps and spasms, and temporal mandibular (jaw) joint difficulty.

COMPLICATIONS May occur or be discovered during treatment. They can include: blocked canals due to fillings or prior treatment, natural calcification, or broken instruments. Unintended perforations of the tooth, root, sinus cavity or nerve canal. Damage to existing dental work such as crowns, fillings, bridges, or porcelain veneers. Loss of tooth structure in gaining access to canals and cracked or fractured teeth.

MEDICATIONS May cause nausea, vomiting, allergic reactions, drowsiness and lack of awareness and coordination (which may be intensified by the use of alcohol, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of some prescribed medications. Antibiotics may affect the effectiveness of birth control pills.

TREATMENT OPTIONS Include endodontic treatment, postponing treatment, and tooth extraction. Risks involved in these choices might include, pain, infection, swelling, loss of teeth, infection to other areas, and deleterious effects on your overall health.

CONSENT I the undersigned, being the patient, parent or guardian, consent to the performing of the procedure decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal, I will need to return to my general dentist for a permanent restoration, such as a crown or filling. I realize that a check up x-ray should be taken in six months by my general dentist or by the treating endodontist. I have carefully read the above statement and give my consent for the procedure.

The purpose of this document is not to alarm you. We have been advised not to begin treatment on anyone who has not read and signed this form.

Pursuant to Public Act 488, an HIV antibody test may be performed on me if a doctor or staff member from Endodontic Specialists sustains a percutaneous, mucous membrane, or open wound exposure from my blood or other body fluids.

Signature of patient or guardian ______________________________ Date ________________

Signature of witness ______________________________________ Date ________________

Endodontic Specialists, P.C.

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence
2. A review entity's functions
3. A claim for payment of fees
4. A third party payer's examination of records
5. A court order as part of a criminal investigation
6. An identification of a dead body
7. A licensure investigation; or
8. An abuse, neglect or domestic incident.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PLEASE SIGN THIS FORM UNDER THE HEADING "PATIENT ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

PLEASE SIGN THIS FORM UNDER THE HEADING "PATIENT CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have today received a copy of Notice of Privacy Practices

______________________________ ______________________________
Patient Signature Date

____
Patient Name (please print)

PATIENT CONSENT

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment.

______________________________ ______________________________
Patient Signature Date

____
Patient Name (please print)

For office use only (below)
Patient refused to sight_____
An emergency situation prevented the patient from signing the acknowledgment. ______________________
The following circumstances prohibited the patient from signing the acknowledgment. ______________________
____

Office personnel signature: ______________________________ Date: ______________

Office personnel printed name: ______________________________