I, (print name) _____,hereby authorize

Dr. (print name) _____ to perform root canal treatment on the following tooth (teeth):

_____

_____

_____

_____

_____

The nature and purpose of root canal treatment, and possible alternative methods of treatment have been explained to me, and I fully understand them.

I understand that during the treatment I may have periods of discomfort.

I further understand that many factors contribute to the success of root canal treatment and cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of these factors are: my resistance to infection, the location and shape of the canals, etc.

I have been informed that should the treatment have to be discontinued before completion, or if it fails following treatment, other procedures may be necessary to save the tooth, or it may have to be extracted.

I further understand that during and following the treatment, I am to contact the doctor's office if I have any additional questions, or I experience any unexpected reactions.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all my questions answered.

_____ _____

Patient's Signature | If a Minor, Signature of Parent Or Guardian

_____ _____

Witness Signature | Doctor's Signature

_____

Date