INFORMED CONSENT FOR ENDODONTIC TREATMENT

You have the right to be informed about your condition and the recommended treatment(s) so that you can make an educated decision as to whether or not to undergo the recommended procedure(s). You should understand the possible risks involved and the expected benefits. This disclosure is not meant to alarm you. Its purpose is to provide information so that you may give or withhold your consent.

I, _____ do hereby voluntarily grant my informed consent to the following treatment(s)

Procedure	Procedure Description	Site (tooth number)

by Dr. Monardo for myself.

I understand that | may change the status of my voluntary informed consent at any time before the procedure.

I understand the written and /or verbal information provided to me by Dr. Monardo. The normal course of treatment, expected outcomes, associated risks and complications have been thoroughly explained to me. I understand that the risks and complications resulting from this procedure might include but are not limited to:

Pain, bruising, swelling, bleeding and/or infection that may require additional treatment.
Gum recession.
Damage to nerves causing temporary or permanent numbness of the chin, tongue, lips, face or palate.
Damage to teeth, fillings or other dental restorations.
Damage to the sinus.
Exposure of crown margins or roots.
Ensuing or persistent infection of the treated tooth.
Additional treatment may be necessary (surgical root canal treatment).
Loss of previous restoration.
Broken instruments in the canals.
Root perforation.
Root resorption.
Root crack or fracture.
Crown fracture.

I understand that no treatment is also an option. The consequences of no treatment have been explained to me. I have chosen this treatment over the alternatives that have been explained to me. I understand that I will be given instructions to follow after the completion of the above listed treatment(s) and I agree to follow these instructions closely.

I understand that fees quoted are estimates only and subject to change depending on the actual treatment performed. I understand that unless special financial arrangements have been made in advance, payment is required at each visit.

I have had the opportunity to ask questions and I am fully satisfied with the answers I received.

_____	_____	_____
Patient Name	Patient or Legal Guardian Signature	Date

_____	_____	_____
Witness Name	Witness Signature	Date