ARI DENTAL OFFICE

CONSENT FOR ENDODONTIC TREATMENT

Patient's Name_____ **Date** _____

Procedure(s)_____

Dr. Aram Mohajeri has explained to me that there are certain inherent and potential risks associated with the above mentioned treatment, procedure or sedation. The risks include yet are not limited to.

Towards this aim of a mutual sharing of information, we feel it is important to advise you of the reasonably foreseeable risks of endodontic therapy. The following is important information you should consider to aid your treatment decision.

- **Root canal therapy is a procedure designed to retain a tooth that may otherwise require extraction. Root canal therapy has a very high degree of success. However, it is a biological procedure, and results cannot therefore be guaranteed.**
- **Approximately 5% to 10% of teeth that have undergone non-surgical root canal therapy may require retreatment or root-end surgery.**
- **Despite our best efforts, approximately 5%. of endodontically treated teeth may fail and require extraction.**
- **Final restoration (crown) of the tooth that has undergone root canal therapy is essential to root canal success and retention of the tooth. A final restoration should be completed within 30 days of root canal therapy.**

I have read this consent and have been offered a full explanation of its contents. I understand this document and hereby give my informed consent for dental treatment.

_____ _____

Patient/Parent/ or Guardian signature **Date**

_____ _____

Doctor's signature **Signature of witness**