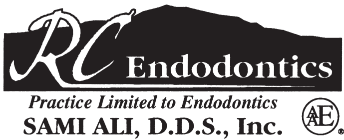

WELCOME TO OUR OFFICE
Thank you for taking the time to give us the following confidential information.

CONSENT

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

I also understand that only the root canal treatment will be performed at this office. The permanent restoration (filling, onlay, crown) will be done by my regular dentist.

I also acknowledge full responsibility for payment of services and agree to pay for them, in full, at or before completion. I authorize my insurance carrier to issue the benefits directly to this office and also authorize release of information necessary to process insurance claims. I understand that payment of services is my responsibility and not the insurance company's and all unpaid balances are subject to the maximum service charge allowed by law.

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Patient/Parent Signature **Date**

FOR OFFICE USE ONLY

Health History Update: ____

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Signature **Date**