

# **SOUTHEAST ENDODONTICS, PC**

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## **Informed Consent for Endodontic Treatment**

**Proposed Treatment: Root Canal Therapy on tooth # \_\_\_\_\_**

I understand that root canal therapy includes opening up a tooth through the biting surface, cleaning out bacteria, debris and any remaining pulp tissue (nerves and blood vessels), and then filling the root canal space. Root canal treatment is known to be highly successful, but success cannot be guaranteed. Usually, the alternative to root canal therapy is removing the tooth. Other treatment choices may include no treatment or waiting for more definitive signs and symptoms to develop. Occasionally, despite all efforts, the tooth may still require retreatment, surgery, or extraction.

I have been informed of the need for root canal services listed above and understand the possible complications of any treatment rendered, including damage to existing fillings, crowns or bridges, breakage of a metal instrument in the tooth, overextension of the filling material beyond the end of the root, blocked canals, perforations (extra openings) of the crown or root into the bone, tooth fracture, pain, and infection. These complications are in addition to the usual risks of general dental treatment and local anesthetic administration. I understand the possible consequences of not receiving treatment in the near future may include the risk of infection, pain, and the possible loss of the tooth and/or surrounding bone.

I have been informed why it is important to have a "permanent" filling placed in, or a crown (cap) placed over the tooth soon after root canal treatment is completed. Failure to have the tooth restored in this manner could result in contamination of the root canal and failure of the root canal treatment, possibly leading to the cause of retreatment or loss of the tooth. After the root canal treatment is completed, a temporary filling will be used to seal the tooth and it will be necessary to seek a "permanent" filling or crown from your dentist.

### **Patients with Dental Insurance**

When treatment is started the staff will be asking me for an initial payment. A claim will then be forwarded to the insurance company. After payment has been received from the insurance company, I will either receive a bill for any remaining balance, or a refund check if the insurance company has paid more than anticipated. I further understand that if for any reason my dental claim is rejected, I am responsible for payment in full for all fees incurred.

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Patient Name (print)

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Patient or Guardian (Signature)

Date



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# Acknowledgement of Receipt of Notice of Privacy Practices

\*\*\* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*\*\*

**I have received a copy of this office's Notice of Privacy Practices.**

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Patient Name (print)

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Patient or Guardian (Signature)

Date

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_  
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