CONSENT FORM

Endodontic (Root Canal) treatment is performed in an attempt to save a tooth which otherwise might require an extraction. As a quality dental provider, we believe that a patient must be well informed about any treatment procedure and his/her consent is given before performing any treatment. The purpose of this form is to inform our patient of the risk and complication that might occur, on infrequent occasions, during a Root Canal Treatment.

Although Root Canal therapy has a high degree of success, like any other health treatment, no guarantee can be given. Root Canal treatment generally takes one to two visits and requires x-rays and local anesthetic. In some cases, the tooth may re-quire re-treatment, apical surgery or even extraction.

In case of re-treatment, some complication may be encountered due to previous treatment such as blockage, perforation or broken instrument. In addition, root fracture is another key reason for failure of a Root Canal therapy, which some cracks extend from the crown down into the roots and are invisible and undetectable. Whether the fracture occurs before or after the root canal treatment, the fractured tooth may require an extraction. If a surgical approach becomes necessary at any time during the course of the treatment or recall period, a separate fee will be quoted.

There are different types of Endodontic surgery that includes Hemisection (dividing the tooth in half), Apicoectomy, Root Amputation, and Injured Root repairing. In very complex cases a procedure called intentional re-plantation may be performed, in this case a tooth is extracted, treated, and then replaced in the socket. These procedures are designed to help saving the patient's tooth; again, there are no hundred percent guarantees with such surgical procedures.

Following completion of Endodontic treatment, a patient must return to his/her general dentist for placement of appropriate restoration for the treated tooth. It is emphasized that this be done as soon as possible (after 10 days) in order to protect the tooth from subsequent fracture or decay. X_____ (Patient's initial)

Root Canal treatment in general is a safe and effective procedure. However, there are certain inherent and potential risks that may occur during the procedure such as: pain and swelling; sensitivity; infection and bleeding following surgery; numbness or tingling sensation in the lips, tongue, chin, gums, and cheek, which is transient but seldom permanent; jaw muscle cramps and spasms; refers pain to ear, neck and head; damage to existing crowns and bridges; discoloration of the tooth ' sinus or tooth perforation; broken instrument; calcified or curved canals that cannot be negotiated; treatment failure; reaction to anesthetic or medication; discoloration of the face; and also antibiotic that may inhibit the effectiveness of birth control pills.

NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed, as well as how you can access this information.

At our dental office, we always keep the health information of our patients secure and confidential. A new law requires us to continue maintaining that privacy, to give you this notice and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment For example: We may use or disclose your health information for payment of your services. We may use or disclose your information with our business associates, such as collection agency. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. We may also want to call and remind you about your appointment. In case of an emergency, we may disclose your health to a family member or another person who is responsible to your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without prior written authorization. You may request in writing that we do not use or disclose your health information without your prior written authorization. You have the right to transfer copies of your health information, with a few exceptions. We will charge you a fee of $25.00 per copy. You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing. You have the right to receive a copy of this notice without any charges. If we change any of the detail of this notice we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W Room 509 F, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy office in our office at regular office hours. This notice gees into effect as of April 14, 2003

Acknowledgement:

I have read and understand this notice of privacy practices

Sign: _____ Date: _____

Print Name: _____

If signed as a parent or guardian, please print the name of the patient below

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