INFORMED CONSENT for ENDODONTIC TREATMENT

Patient File No	:	2500			
Patient Name	:	Blesie Gomez	**DOB**	:	06-Nov-1994
Nationality	:	Philippine	**Gender**	:	Female
Emirates ID	:	784-1994-3054292-0	**Date**	:	09-Feb-2024

Tooth(s) # :

Prognosis: :

I voluntarily consent to endodontic (root canal) treatment that has been recommended. I understand that the goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, it is a dental-biological procedure, whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally undiagnosed or hidden problems arise. I understand that this procedure will not prevent future tooth decay or a possible fracture, and that occasionally a tooth that had root canal treatment may require re-treatment, surgery or tooth extraction.

The treatment has been fully explained to me including the risks involved. I have been informed that complications might include, but are not limited to:

a) Perforation of the canal with instruments, which could result in the need for root canal surgery or the loss of the tooth.

b) Instrument breakage in the canal, which may require re-treatment, root canal surgery or extraction.

c) Incomplete healing, which may require re-treatment and/or root canal surgery or extraction.

d) Post-operative infection, which may require additional treatment and/or the use of antibiotics

e) Tooth fracture, that may require additional treatment or tooth extraction.

f) Referral to a specialist if any unexpected difficulties occur during treatment.

g) Post-treatment discomfort, altered feeling of the soft-tissues of the mouth.

I am aware that the condition of the tooth will worsen and that other systemic (medical) problems could possibly develop if the recommended procedure is not done.

Other Treatment choices:

The following other treatment options might be possible:

a) No treatment at all;

b) (b) Waiting for more definitive development of symptoms;

c) (c) Extraction: To be replaced with either nothing, a denture, a bridge or an implant.

After the completion of the root canal procedure, you will be referred back to your restorative dentist for the permanent restoration (filling, crown, onlay). Failure to have the tooth properly restored significantly increases the possibility of re-infection, failure of the root canal procedure and/or tooth fracture.

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed

Patient's Initials:

I understand that ALL medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

In the event I wish to discontinue the treatment, I have been informed of and understand the risks associated with leaving my condition untreated. I am aware that my overall health may be affected by my decision. I will not hold the dentist, dental staff, or anyone associated with the dental practice responsible for changes in my overall health stemming from this condition. I have had the chance to ask questions and express concerns about my dental condition, thetreatment options, and my refusal of treatment. The undersigned provider has answered all my questions and addressed all my concerns. I understand the full scope of the situation and am making an informed decision.

8. Informed Consent:

I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired result, which may or may not be achieved. The fee (s) (if applicable), for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize and / or his / her associates to render treatment and administering or any medications and / or anesthetics deemed necessary for my treatment.

I have been given the opportunity to ask any questions regarding the nature and purpose of crown and / or bridge treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired result, which may or may not be achieved. The fee (s) (if applicable), for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Dr. Tarona Azem Subba and / or his associates to render treatment and administering or any medications and / or anesthetics deemed necessary for my treatment.

☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

☐ I refuse to give my consent for the proposed treatment(s) as described above and have been explained the potential consequences associated with this refusal.

Sign here, only if all of your questions have been answered to your satisfaction

Blesie Gomez — 09-Feb-2024 — #13

Patient's name — **Signature of Patient Legally authorized Representative** — **Date**

09-Feb-2024

Dr. Tarona Azem Subba
Specialist Periodontics
DENTISTREE DHA-0135726?-001
DENTISTREE DENTAL CLINIC

Witness Signature — **Date**

09-Feb-2024