NORTHSHORE ENDODONTICS, P.C.
JOHN E. SULLIVAN, Jr., D.D.S., M.S.
414 S. NORTHSHORE DRIVE
KNOXVILLE, TN 37919
865-212-9680

Name: _____ Date: _____

INFORMED CONSENT

Please review the following informed consent. You will be required to sign it prior to the initiation of the indicated treatment. All signatures must be by parent or guardian if the patient is under the age of 18.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by John E. Sullivan, Jr., D.D.S., M.S. and any assistant he may require. I agree to the use of local anesthesia, oral sedation, antibiotics and medications depending on the judgment of Dr. Sullivan. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which is rarely protracted and even more rarely is permanent. An allergic reaction could occur from materials used in our endodontic care.

I understand that root canal therapy is a procedure to retain a tooth which otherwise requires extraction. Although root canal therapy has a very high degree of clinical success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require treatments, surgery, or even extraction. I also understand that besides the root canal therapy and associated surgical procedures, occasionally restorative procedures are necessary to aid in attempting to maintain the tooth in the mouth like core buildups, post and cores, temporary crowns and fillings. My family dentist will place the final crown or filling. During treatment there is the possibility of instrument breakage within the canal, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, shrinkage of the gum around the crown and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amenable to endodontic treatment at all. Other treatment options would include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth and infection to other areas.

I understand that medications for discomfort may cause drowsiness, which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives (a rash) and intestinal problems and if any of these reactions occur, I am to call the doctor immediately. I understand that it is my responsibility to report any changes to my medical history.

All reasonable finance charges, collection fees, court cost, and legal fees will be my responsibility if such action becomes necessary.

The doctor or his assistants have answered all of my questions, and I fully understand the above statements in this consent form.

Procedure: _____

***Patient Signature:** _____ Date _____ Dr. Initials _____ Witness _____

Northshore Endodontics, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

***I,** _____, have reviewed a copy of this office's Notice of Privacy Practices.

***Please Print Name** _____

***Signature**_____ Date_____

For Office Use Only

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

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify) _____

_____