I UNDERSTAND that dental treatment requiring PULPOTOMY THERAPY PROCEDURES, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) I understand that a pulpotomy is an interim treatment done with the intention of temporarily preserving a vital permanent tooth without removing all of the pulpal or nerve tissue. It is also a procedure which helps to maintain a baby, or primary tooth that is infected, thus preventing premature loss.

_____(initials) Even though it is anticipated that this treatment may extend the time in which a tooth will remain vital until further necessary procedures may be successfully performed at a more appropriate time, it will be necessary to perform complete root canal therapy as soon as practical. Care should be taken not to unduly delay completion of the root canal process. Referral to an endodontic specialist may be necessary as determined by the attending dentist.

_____(initials) There is always the possibility of injury to the nerves of the face or tissues of the oral cavity during the administration of anesthetics, or during the treatment procedures which may cause a numbness of the lips, tongue, tissue of the mouth, and/or facial tissues. This numbness is usually temporary, but may be permanent.

_____(initials) Inasmuch as the crown portion of the tooth may have been weakened due to the extensive nature of the procedure and/ or that the tooth injury or disease which necessitated this procedure, the tooth may be more susceptible to fracture or breakage. Removal of vital tissue within the tooth causes it to dehydrate, and that can lead to fracture.

_____(initials) Should the tooth structure which is remaining appear to be excessively compromised, it may be necessary to place a temporary crown on the tooth in order to preserve it.

_____(initials) Should the tooth not heal properly, experience an extensive fracture, or become unable to have complete root canal therapy performed, extraction of the tooth may be the only alternative.

_____(initials) In most cases, once the pulpal tissue has been removed, and the initial pain has subsided, the tooth usually becomes pain free. However, in some cases, severe pain or extreme sensitivity will persist. If so, it is the patient's responsibility to notify the dentist immediately.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

Remainder of This Page Left Blank Intentionally
Signature Page to Follow

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warranties have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date
Tooth Number(s)	Witness to Signature	Date
Healthcare Provider's Name	Signature of Healthcare Provider	Date

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