Carolina Endodontics Specialty
Mallory Jane Hackbarth, DMD, MS
Practice Limited to Endodontics

Patient Information and Consent to Treatment Form

Welcome! Your dentist has referred you to our office for Endodontic (Root Canal) Treatment.

We believe that a patient must be well informed about any procedures and their consent given before performing any treatment. The purpose of this is to inform our patient of the treatment as well as any risks and complications that may occur infrequently during Root Canal Treatment.

We begin treatment with a diagnostic evaluation and consultation and consists of x-rays, an oral examination and history, plus appropriate testing. Root canal treatment generally takes 1 or 2 visits and requires several x-rays. A root canal treatment is performed using local anesthesia and consists of the removal of the diseased tissue within the tooth, and sealing of the canals.

As an endodontic specialist, this office performs only root canals and associated services. Endodontic treatment is performed in an attempt to save a tooth and relieve pain and infection in the tooth. Although root canals have a very high degree of success, like any other medical treatment, results cannot be guaranteed. In cases with persistent infection the tooth may require retreatment, apical surgery, or even extraction.

At the completion of endodontic treatment, you must return to your dentist for placement of a final restoration, returning the tooth to proper function. **It is important that this be done as soon as possible to protect the tooth from subsequent fracture or decay.**

Possible Risks Associated with Endodontic Treatment

1. Unpredictable reaction to local anesthetics and medication used in connection with treatment.
2. Hairline fractures within the roots of the tooth, as well as cracks, fractures, and breaks in the crown of the tooth. A fractured tooth may require an extraction.
3. Chipping, breaking, or dislodgement of permanently cemented crowns, inlays, and bridges.
4. Tenderness and soreness of the teeth and gums, along with tingling and swelling, which is transient but seldom permanent.
5. Untreatable canals, stripping and perforation due to severe canal curvature, severe chamber or root calcification and/or obstructions.
6. Separation of instruments that may be not recoverable.
7. Underfill and overfill of the filling material (gutta-percha)
8. On some occasions during the course of treatment, a surgical approach may become necessary. A separate fee will be quoted for this procedure.

Alternatives to Endodontic Treatment and Associated Risks

1. Extraction of the tooth, with loss of function and esthetics.
2. No treatment may result in the formation of abscesses and cyst in the jawbone.
3. No treatment may result in the spread of infection to adjacent teeth and or oral structures.

During the course of treatment, every effort will be made to achieve successful results and the comfort of our patients. Please do not hesitate to ask questions in regards to the procedures being performed.

Patient: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

At Carolina Endodontics Specialty office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to 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; a review of your file by a specialist doctor who we may involve in your care.
We may use or disclose your health information for payment of services. For example; we may need to send a report of your progress to your insurance company.
We may use or disclose your health information for our normal healthcare operations. For example, a stall member will enter your information into our computer system.
We may share your health information with our business associates, such as a billing service.
We may also use your information to contact you. For example, we will contact you regarding upcoming appointments. If you are not home, we may leave a message on the answering machine or with the person who answers the call.
In case of an emergency, we may disclose your health information to a family member or another person who is responsible for your care.
We may release some or all of your 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 with out your prior written authorization.
You may request in writing that we do not use or disclose your health information as described above. We will do our best to fulfill your request.
You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
You have the right to transfer copies of your health information to another practice. We will mail your files to you.
You have the right to see and receive a copy of your health information, with a few exceptions. Please give us a written request regarding the information you want to see. If you want a paper copy of your records, we may charge you a reasonable fee.

You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include that in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new additional information.

You may file a complaint with the Department of Health and Human services, 200 Independence Ave., 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 or office at 803-802-3681. This notice goes into effect as of December 1, 2005.

****Please list below those who you would like your information shared with. (Name and Relationship to the Patient)****

_____

Acknowledgment:
I have read and understand.

Print: _____

Signature: _____ **Date:** _____