

Dr. Tom Shackleton D.D.S.

General Dentist

PRACTICE LIMITED TO ENDODONTICS

#18 - 3919 Richmond Road, SW, Calgary, Alberta T3E 4P2

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1. I hereby authorize Dr. Shackleton and any other agents or employees of Dr. Shackleton and such assistants as may be selected by any of them to treat the condition(s) described below:

2. The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be: _____

3. The prognosis for this (these) procedure(s) was described as: _____

4. I have been informed of possible alternative methods of treatment, including no treatment at all.
5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive:
Swelling; sensitivity; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments - perforation of tooth, root, sinus), medications, anesthetics, and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills.
6. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
7. I have been given the opportunity to question Dr. Shackleton concerning the nature of treatment, the inherent risks of treatment, and the alternatives to this treatment.
8. This consent form does not encompass the entire discussion I had with Dr. Shackleton regarding the proposed treatment.
9. I understand that Dr. Shackleton is not a certified specialist in Endodontics, but is a general dentist that has restricted his practice to Endodontics.

Patient's signature _____ Date _____

Doctor's signature _____ Date _____

Witness signature _____ Date _____