



Sofia, 6 Stefan Stambolov Blvd and 26A, Knyaz Al. Dondukov Blvd, www.medstom.bg

**DECLARATION
FOR
INFORMED CONSENT FOR ROOT TREATMENT**

I, hereby authorize the dentist from (the name of the medical establishment) to perform the root treatment of the following tooth (teeth):

.....

The essence and purpose of root treatment, as well as possible other alternative methods of treatment, have been clarified and I fully understand them. I realize that during treatment I may have periods of discomfort.

I also realize that many factors contribute to the success of the root treatment and they cannot be determined in advance. Therefore, in some cases, treatment may be interrupted before it is completed, and/or may prevent further treatment. Some of the factors that influence it are: my resistance to infections, the location and shape of the canals, etc.

I was informed that if there is a need for a discontinuation or termination of the treatment, it might be necessary to perform other procedures for the preservation of the tooth or for it to be removed.

I realize that during this treatment, it is my duty to contact the doctor's office in the event of additional questions or unexpected reactions.

I admit that I have not been given any guarantees of any kind with regard to the results that can be achieved.

I discussed all the above information with my dentist. I was answered all the questions.

I have been advised that crown placement may be necessary to ensure maximum protection of the tooth after the root treatment. I was informed that the crown (s) placement is a separate dental operation that is not part of the current treatment and is not included in the cost of treatment. Additional dental care is required to make the crown.

Date

Patient/Parent/Guardian:

Signature

Dentist:

Signature

Witness: Name and signature