

**OKLAHOMA DEPARTMENT OF CORRECTIONS
ENDODONTIC AND ORTHODONTIC CONSENT**

I certify by initialing the appropriate information below that I have read and understand that information, and had the opportunity to discuss my treatment with the dentist.

- _____ 1. I understand that removal of my orthodontic appliances may cause my teeth to return to original or near original position in my mouth. I accept this and understand that the State of Oklahoma/Department of Corrections does not provide orthodontic therapy.
- _____ 2. I am within one year (calendar) of my anticipated release from the correctional system. I understand that the dentist is performing a procedure (pulpectomy/pulpotomy) which is considered a temporary and/or partial treatment. I understand that, upon release, I will be responsible for obtaining completion of the endodontic procedure at my own expense. I understand that the consequences of not completing this treatment may be reinfection, fracture, and/or loss of the tooth/teeth number(s): _____.

Inmate Signature: _____ Date: _____

Witness: _____ Date: _____

Dentist's Signature: _____ Date: _____

Inmate Name: (Last, First)

DOC #

To be placed in Section 5 of the inmate's medical record in accordance with OP-140106 entitled "Healthcare Record System."