INFORMED CONSENT FOR REMOVAL OF ROOT-CANALED OR DEAD TEETH

I have been fully informed that the American Dental Association and most dentists do not advocate that extraction of root-canaled, crowned, heavily filled, grossly decayed, pulp exposed, or dead teeth; or serviceable teeth that might appear as "unremarkable" or "normal" on the radiograph (x-ray negative), teeth deemed to be treatable by root-canal therapy and restorative procedures, or dying teeth and especially those teeth that might be asymptomatic (without pain or sensitivity) locally.

Most members of the American Association of Endodontists (root canal specialists) do not acknowledge that root-canaled teeth can cause local and/or systemic diseases. Said association is also of the belief that the bacteria and toxins present in a root-canaled tooth do not cause harm to neighboring or remote sites in the body.

I understand that the procedure performed is a surgical one possibly requiring the creation of a gum flap followed by tooth extractions, debridement of diseased bone, and flap closure with sutures. Most dentist and oral surgeons are unaware and do not perform this critical procedure, thereby, leaving diseased bone behind resulting in residual osteomyelitis and/or osteonecrosis (dead bone) or other pathology. I understand that extracted tooth/teeth and debrided bone and soft tissues *may* be sent for biopsy service. *If* this occurs, there is a separate fee as determined by the Oral Pathology Laboratory, which performs the biopsy service.

I understand that there is no way to determine if the extraction of any tooth/teeth will have any positive effect on my health or specific health complaint. I further understand that my chewing efficiency and function may decrease, and my facial appearance may be adversely impacted. I may also experience myofascial pain or TMJ symptoms. The spaces remaining after oral surgery may need to be restored with fixed or removable dental devices at additional costs.

I understand that there can be no guarantee given regarding the ability of my body to heal. Poor health, weak body constitution, compromised immunity, inherited or acquired tendency to certain diseases or organ weakness, poor nutrition, lifestyle, and countless other stressors are all factors which can influence the treatment outcome.

I have read the above disclosure carefully, and have asked for clarification on any matter that I do not understand. I sign this document of my own free will and consent. I am not under any duress (pressure) to sign this document.

Patient Name:_____ Date:_____

Patient or Guardian Signature:_____