
Consent for extraction of a root filled tooth (root canal) or teeth

I, _____ authorize Dr _____
to remove my root canal treated tooth and/or teeth, # _____. I also give
Dr _____ the authority to extract any tooth or teeth that
require root canal therapy. I have been fully informed that the Australian Dental
Association and most dentists do not advocate the extraction of root canal teeth
especially those that are asymptomatic (without pain or sensitivity). The Australian
Association of Endodontists (root canal specialists) does not believe that root canal teeth
can cause local and/or systemic disease. They are also of the belief that the
bacteria present in a root filled tooth does not cause harm to other remote sites in the
body.

I understand that the procedure performed by Dr _____ to remove a root
canal tooth is sometimes a surgical one requiring the creation of a gum flap,
followed by tooth extraction, diseased bone removal and final flap closure with
sutures. Most dentists and oral surgeons do not perform this critical procedure
thereby leaving diseased bone behind resulting in residual osteomyelitis and /or
osteonecrosis (dead bone). It is my understanding that a biopsy of the tooth and
surrounding tissues both hard and soft may be performed. This will be a separate fee
and determined by the Oral Pathology Lab which performs the biopsy.

I understand that there is no way to determine if the extraction of a root canal tooth
will have any positive effect on my health or specific health complaint.

I understand that by losing one or more teeth that my chewing function may be
compromised and the spaces that remain after the extraction may need to be restored
with some fixed or removable dental device.

I understand that there can be no guarantees given regarding the ability of my body to
heal. I understand that healing may be less than satisfactory. This may result in
recurrent pain, recurrent infection or re-infection and thus require further surgery or
treatment.

I have read the above information carefully. I have asked for further information on
any matter I did not understand. I sign this of my own free will and consent. I am not
under any duress to sign this document.

Patients Signature: _____ Name: _____

Doctors Signature: _____ Name: _____

Dated: _____