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Consent for Extraction of a Root Filled Tooth (root canal) or Teeth

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

I understand that the procedure performed by Dr. Medlock of removing a root canaled tooth is a surgical one requiring the creation of a gum flap followed by tooth extraction, removal of diseased bone, and a final flap closure with sutures. Most dentists and oral surgeons do not perform the critical procedure of removing the diseased bone, which when left intact, may result 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. There will be a separate fee charged for the histopathological examination of the biopsy specimen. There may also be a toxicity test performed with a separate fee involved. The toxicity test will give us an indicator of the level or degree of toxicity of substances emanating from the tooth involved.

I understand the RISKS include (but not limited to): complications resulting from the dental surgery or the use of dental instruments, drugs, medicines, analgesics anesthetics and injections. These complications may include: swelling, sensitivity, bleeding, bruising, pain, infection, numbness, and/or tingling sensation in the lip, tongue, chin, gums, cheeks and teeth (these are transient, but on infrequent occasions may be permanent), reaction to injections, changes in occlusion, jaw muscle cramps and spasm, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reaction, delayed healing, sinus perforations, bone fracture, root fragments left in jaw, stretching of the corners of the mouth with resultant cracking and bruising, treatment failure.

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

I understand that by loosing 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.

Signed_____Date_____

Witness_____