CONSENT FORM FOR EXTRACTION OF ROOT-CANALED TEETH, OR CROWNED, OR HEAVILY FILLED, OR GROSSLY DECAYED, DEAD OR DYING TEETH

I, the undersigned, authorize Dr. Stuart M. Nunnally, Dr. Lane B. Freeman, Dr. Candice Owens or Dr. Rodney Teague to remove my root-canal treated teeth #______________________________, or crowned, or heavily filled, or grossly decayed, or pulp exposed, or dead, or dying, or periodontally hopeless teeth #_____________________.

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

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 dentists 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 will be sent for biopsy service. 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 noted above 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. I have been given the opportunity to see photographs and/or plaster models of other patients similarly treated so I have good understanding of my treatment and expected outcome.

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 have been offered pro and con printed material, books, web sites for my study.

I sign this document of my own free will and consent. I am not under any duress (pressure) to sign this document.

______________________________________	______________________________
Dr. Stuart M. Nunnally, Dr. Lane B. Freeman or Dr. Candice H. Owens	Patient/ Legal Guardian
______________________________________	______________________________
Date	Date