Open and Affordable Dental

# CONSENT FOR PERIODONTAL TREATMENT

Patient's Name: _____

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.**

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

My diagnosis is: ☐ Periodontal Disease

My planned treatment is: ☐ Scaling and Root Planing (Deep Cleaning)

Alternative treatment methods include: ☐ None

_____ 1. My doctor has explained that there are certain potential risks and side effects of not proceeding with treatment, some of which may be serious. They include the following and others:

- Gum recession
- Bad breath
- Inability to perform adequate dental hygiene
- Loosening of teeth
- Abscesses or infection
- Pain
- Poor chewing
- Tooth sensitivity
- Tooth movement
- Worsening of my gum condition
- Deeper pocketing
- Premature tooth loss with need for replacement

_____ 2. I understand that there are risks associated with the proposed treatment including:

- Swelling, bleeding and pain, Hot and cold tooth sensitivity, Gum shrinkage with exposure of crown margins or edges
- Dental cosmetic changes and speech changes,Possible loss of taste sensation, Infections or abscesses
- Loss of teeth, Prolonged numbness, Tooth mobility, Food impaction, Root staining
- Restrictions in mouth opening (secondary to swelling or to stress on the jaw joints),Tissue loss
- Continued or recurrent gum disease, Implant loss, Root canal therapy, TMJ treatment
- Other: _____

I have not been given any guarantee or warranty of success for this treatment, and understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same, better or worse after treatment and that ongoing care may be necessary.

I understand that to aid in successful treatment and to lessen the dangers of complications, I must meet certain requirements: excellent oral hygiene, proper diet with restrictions on certain hard or chewy foods, strict adherence to instructions about using medications or the wearing of appliances and cooperation in keeping appointments. I have provided a complete and accurate statement of my medical and social history. I have had full opportunity to ask questions about the information on this form and have been given answers that are to my satisfaction.

**CONSENT**

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understood the above and gave my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature: _____Date: _____

Doctor's/Hygienist's Signature: _____Date: _____

Witness's Signature: _____Date: _____