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Patient Name: ______ ______ ______ ______

Last First MI Preferred Name

Informed Consent To Periodontal Treatment

Diagnosis:

Treatment Needed: (Tooth/Teeth/Quadrant)

* ______

I have been informed that I have periodontal (gum) disease and or deformities that could lead to the loss of my teeth. I have been advised that the proposed therapy is intended to extend the life expectancy of my teeth. This consent form outlines the treatment program, its expected consequences, and limitations.

Treatment Procedures:

* Oral hygiene/disease prevention
* Bacterial culturing
* Chemical pocket irrigation and or placement of subgingival medication
* Biopsy of tissue for microscopic evaluation
* Polishing and scaling
* The administration of anesthetic agents topically and by injection
* Root planing and or curettage (tooth and/ or gum scraping)
* Occlusal/bite adjustment
* Tooth straightening procedures with fixed and/or removable appliance(s)
* Temporary splinting
* Biteguard
* Periodontal surgery (gingivoplasty; flap surgery with/without osseous contouring; osseous/alloplastic and/or bone bank grafts; soft tissue grafts; connective tissue grafts; frenulectomy; fiberotomy; placement of special membranes for guided tissue regeneration; exostosis reduction/removal; crown lengthening)
* Ridge augmentation
* Extraction of teeth or roots as determined during surgery
* Root desensitization therapy
* Oral and/or intravenous sedation
* Periodontal maintenance therapy (professional recall care)
* Dental Radiographs/X-rays

Alternatives:
I have been informed that possible alternatives to the above treatment include:

* Maintenance therapy only
* Root planing/curettage and maintenance therapy only
* Pre-surgical and maintenance therapy only
* Extraction(s)

We have discussed, however, that the procedures first recommended should be performed due to improved prognosis.

Non-Treatment Risks:

I further understand that if no treatment is rendered, the risks to my dental health include, but are not are not limited to, the following:

*** Premature loss of teeth**
*** Gum recession**
*** Halitosis**
*** Loosening of teeth**
*** Abscesses (gum boils)**
*** Tooth drifting, flaring or other tooth movement**
*** Further deepening of periodontal and/or pus pockets**
Patient Initials

Treatment Risks:
Risks include but are not limited to:

* Allergic or other reactions
* Swelling
* Pain
* thermal sensitivity
* Exposure of margins of crown(s) and/or root surfaces
* Damage to adjacent teeth
* Phonetic interferences
* Infection
* Tooth mobility
* Food impaction and spaces between teeth
* Temporary restricted mouth opening
* Numbness of jaw or gum nerves, which can be permanent
* Dislodging of current restoration(s) and/or crown(s) - this may require replacement at your general dentist's office at additional cost
* Jaw fracture

I understand these risks as they have been explained to me and as written above:

Consent To unforseen Conditions During Surgery:

If any unforeseen condition should arise in the course of the operation, calling for the Doctor's judgement for procedures in addition to or different from those contemplated, I further request and authorize the Doctor to do whatever he may deem advisable.

Photographs-Observers:

In furtherance of the progression of dentistry and the dental health of the public, I do hereby consent to photographs being taken of my oral and facial structures, and subsequent publication solely for educational and scientific purposes, and to having health professional observers in the examination and/or treatment room for educational purposes. I understand that my Identity will not be revealed to the public without my permission.

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No Warranty:

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth. However, it is Doctor's opinion that therapy will be helpful, and that further loss of supporting tissue pr bone would occur without the recommended treatment.

It has been explained to to me that the long-term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment has been completed.

I certify that I have read fully and have had all of my questions answered so that I understand the above consent to treatment, the explanation therein referred to or made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable sections, if any, were stricken before this document is signed.

Response Date: