CONSENT FOR PERIODONTAL TREATMENT

Patient's Name Date

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: _____
_____

My planned treatment is: _____
_____

Alternative treatment methods include: _____
_____

_____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:

_____ A. Gum recession
_____ B. Bad breath
_____ C. Inability to perform adequate dental hygiene
_____ D. Loosening of teeth
_____ E. Abscesses or infection
_____ F. Pain
____ G. Poor chewing
____ H. Tooth sensitivity
____ I. Tooth movement
____ J. Worsening of my gum condition
____ K. Deeper pocketing
____ L. Premature tooth loss with need for replacement

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

____ A. Swelling, bleeding and pain
____ B. Hot and cold tooth sensitivity
____ C. Gum shrinkage with exposure of crown margins or edges
____ D. Dental cosmetic changes and speech changes
____ E. Possible loss of taste sensation
____ F. Infections or abscesses
____ G. Loss of teeth

____ H. Prolonged numbness
____ I. Tooth mobility
____ J. Food impaction
____ K. Root staining
____ L. Restrictions in mouth opening (secondary to swelling or to stress on the jaw joints),
____ M. Tissue loss
____ N. Continued or recurrent gum disease
____ O. Implant loss
____ P. Root canal therapy
____ Q. TMJ treatment
____ R. 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 understand the above and give 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.
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_____
Patient's (or Legal Guardian's) Signature Date

_____
Doctor's Signature Date

_____
Witness' Signature Date