INFORMED CONSENT TO PERIODONTAL (GUM) TREATMENT

I hereby authorize _____ (hereinafter called "Doctor") and whomever they may designate as their assistant(s), to perform the following treatment and/or surgery upon _____

Diagnosis: I have been informed that I have periodontal (gum) disease and/or deformities that could lead to the loss of certain 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; stomatoplasty; 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)

Alternatives: Further, 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)
- Other _____

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 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

Treatment Risks: Risks of the treatment include, but are not limited to:

- Allergic or other reactions to medications and anesthesia
- Swelling
- Pain
- Thermal sensitivity
- Exposure of margins of crown (caps) and/or root surfaces
- Phonetic interferences
- Infection
- Tooth mobility
- Food impaction and spaces between teeth
- Temporary restricted mouth opening
- Numbness of jaw or gum nerves
- Root resorption (iliac grafts)
- Other _____

Consent to Unforeseen Condition(s) During Surgery: If any unforeseen condition(s) should arise in the course of the operation, calling for the Doctor's judgment for procedures in addition to or different from those contemplated, I further request and authorize the Doctor to do whatever he/she may deem advisable.

Pre- and Post-Operative Instructions: Because of the nature of the proposed treatment and/or procedure, Doctor has advised me that I or _____ (other name) should have nothing to eat or drink after midnight the night before or within four (4) hours of the proposed surgery. Additionally, certain prescribed medication may cause drowsiness, alone or in combination with alcohol or other sedatives. **I or _____ (enter other name) have been advised not to drive or operate dangerous machinery within twenty-four (24) hours of taking such medication.** Accordingly, I or _____ (enter other name) have arranged to be driven and accompanied home by another person.

Photographs or 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.

Experimental Therapy (Special Situations): I fully understand that the procedure, treatment, drug, or device to be used is experimental in nature and not necessarily accepted by medical or dental science at the present time, and that the consequences cannot be predicted.

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 the further loss of supporting tissue or bone would occur sooner without the recommended treatment.

It has been explained 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 at a dental office.

I CERTIFY THAT I HAVE READ FULLY THE ABOVE CONSENT TO TREATMENT AND HAVE HAD ALL MY QUESTIONS ANSWERED SO THAT I UNDERSTAND 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 I SIGNED.

SIGNED: _____

DATE: _____

WITNESS: _____