Consent for Periodontal Treatment

Patient Name: _____ **Date:** _____

I have been advised that my complete periodontal examination has revealed the following condition(s):

_____

My periodontist has recommended the following procedure(s):

_____

_____1. I have elected to treat my condition by the proposed treatment recommendation, rather than no treatment or any possible alternative treatments such as:_____.

_____2. My periodontist has explained to me that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance such risks include, but are not limited to:

a. Swelling, bleeding and/or pain
b. Hot and cold tooth sensitivity
c. Gum shrinkage with exposure of crown margins or edges
d. Dental cosmetic changes and/or speech changes
e. Injury to the nerve underlying teeth resulting in numbness or tingling of the chin, lip, cheek, gums, tongue and/or loss of taste on the operated side; this may persist for several weeks, months or permanently
f. Infections and/or abscesses
g. Loss of teeth, tooth mobility, tissue loss and/or implant loss
h. Food impaction
i. Restrictions in mouth opening (secondary to swelling or to stress on the jaw joints) and/or TMJ pain
j. Root canal therapy
k. Allergic reactions (previously unknown) to any medications used in treatment

_____3. I understand if I elect not to have treatment that there are risks including, but not limited to: 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.

_____4. No guarantee 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, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is my periodontist's opinion that the recommended treatment would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

_____5. 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.

FEMALE PATIENTS ONLY:

_____ It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medications are completed.

I certify that I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to. I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, write and understand English. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient *(or Legal Guardian)* Signature **Date**

Witness Signature **Date**

Doctor Signature **Date**

Rev 8/15