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DENTAL PRACTICE
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A Professional Dental Corporation

INFORMED CONSENT DISCUSSION FOR NON-SURGICAL PERIODONTAL TREATMENT:

Patient Name: _____ Date of Birth: _____

DIAGNOSIS: _____

Facts for Consideration

(*Patient's Initials Required)*

_____ Dental x-rays will be taken to check the condition of the bone that supports your teeth. A thorough examination of your oral cavity will be done measuring the pockets under the gums surrounding your teeth to determine which periodontal treatment(s) your gum condition requires.

_____ Treatment involves removing the bacterial substance known as *plaque*, which is the principal cause of periodontal disease and *calculus*, which is an accumulation of hard deposits on the tooth above or below the gingival margin. **Approximate Cost**: _____.

_____ The treatment involves *scaling* which uses sharp hand instruments o remove calculus, plaque, and bacteria; *curettage* which scrapes any necrotic (dead) tissue and cleans the area or pocket, and *root planing* which smooths and contours the root surface to remove the debris and cementum found in the periodontal pocket. Medications or a special mouth rinse to help control the growth of bacteria may be part of treatment.

_____ The success of the treatment depends in part on your efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow proper home care taught to you by this office.

_____ A topical or local anesthetic may be administered depending on the sensitivity of the area to be treated.

Benefits of Non-Surgical Periodontal Treatment, Not Limited to the Following:

_____ Regular, professional cleanings: create a clean environment in which your gums can heal; reduce the chances of further irritation and infection; make it easier for you to keep your teeth clean; and decrease the cost of replacing teeth lost due to gum disease.

Risks of Non-Surgical Periodontal Treatment, Not Limited to the Following:

_____ **I understand** that my gums may bleed or swell and I may experience **moderate discomfort** for several hours after the anesthesia wears off. There may be slight **soreness** for a few days, which may be treated with pain medication. I will notify the office if the condition persists beyond a few days.

_____ **I understand** that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which would be treated with antibiotics.

_____ **I understand** that holding my mouth open during treatment may temporarily leave my **jaw feeling stiff and sore** and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem, **I must notify your office** if this or other concerns arise.

_____ **I understand** that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that additional surgical procedures are available to protect the exposed areas.

_____ **I understand** that depending on my current dental condition, existing medical problems, or medications I may be taking, these methods alone **may not completely reverse** the effects of gum disease or prevent further problems.

_____ **I understand** that I may receive a **topical or local anesthetic and/or other medication.** In rare instances patients may have a reaction to the anesthetic, which may require emergency medical attention. Because of the anesthesia, I may need a **designated driver to take me home**. Rarely, temporary or permanent nerve injury can result from an injection.

_____ **I understand** that all **medications** have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking which are:

_____

_____ **I understand** that although it is impossible to guarantee perfect results, every reasonable effort will be made to ensure the success of my treatment.

Consequences if No Treatment Is Administered, Not Limited to the Following:

_____ **I understand** that if **no treatment** were administered or on-going treatment was interrupted or discontinued, my periodontal condition would continue and probably worsen. This could lead to further inflammation and infection of gum tissues, tooth decay above and below the gumline, deterioration of bone surrounding the tooth and eventually, the loss of teeth.

Alternative to Non-Surgical Periodontal Treatment, Not Limited to the Following:

_____ **I understand** that surgical methods may also be prescribed to help control my gum disease. I asked my dentist about the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.
Alternatives discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

☐ **I consent to the non-surgical periodontal treatment(s) described above by Dr.** _____

☐ **I refuse to give my consent for the proposed treatment as described above.**

☐ **I have been informed of and accept the consequences if no treatment is administered.**

_____ _____
Patient / Representative Name and Signature Date

_____ _____
Witness Signature Date

FOR DENTIST USE ONLY:

I attest that I have discussed the risks, benefits, consequences, and alternatives to Non-Surgical Periodontal Treatment with: _____ (patient name) who has had the opportunity to ask questions, and I believe my patient understand what has been explained.

_____ _____
Dentist Signature Date