

**CONSENT TO PERIODONTAL
TREATMENT**

Patient Name _____

Date _____

This informed consent and authorization is given to Dr. _____, hereinafter referred to as Doctor, after having first had a full explanations of the nature of the proposed treatment, the alternatives, and the risks.

Doctor has advised me that from the full dental examination that I have received, I have the following condition:

Treatment. I hereby authorize and consent to Doctor and whomever he or she may designate, to perform the following procedures: _____

Alternative Treatments. In making the above recommendation, Doctor has advised me that alternative treatments exist, which may include, but are not necessarily limited to: non-surgical therapy, surgical curettage or cleaning, tooth extractions, implant treatments, and any others described as follows:

I have, however, elected to treat my condition by the proposed treatment, rather than any alternative therapies.

Non-treatment Risks. Doctor has advised me that no treatment is also an alternative. If this condition persists, and is not corrected, the risks may include, but are not necessarily limited to: premature tooth loss, need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, abscesses or infection, pain, poor chewing, tooth sensitivity, tooth movements, worsening of periodontal disease condition, deeper pocketing, and others described as follows: _____

Treatment Risks. I also understand that inherent to any procedure, and because of an individual's variations, certain risks are involved with this treatment. These may include, but are not necessarily limited to: swelling, pain, hot or cold tooth sensitivity, gum recession, abscesses, exposure of crown margins or edges, speaking difficulties, infections, loss of teeth, tooth mobility, food impaction, root staining, oral openings, restrictions, tissue sloughing, continued periodontal disease, implant rejection, root canal therapy, nerve problems, joint pain/disorder, bleeding or other described as follow: _____

I also understand that the proposed treatment contains no guarantee, or warranty of success. Each individual case is unpredictable, making it impossible to surmise results. I further understand that the results may not be to my complete and full satisfaction after the treatment and that my condition may be the same, better or worse after treatment.

I have received a full and complete opportunity to ask questions about the proposed treatment and all questions that I have asked have been answered to my complete satisfaction before I signed this form.

I understand that for successful periodontal results and to lessen the dangers of complication, the following treatment conditions are required of me: compliance with my individualized maintenance program; excellent oral hygiene; strict adherence to instructions in the wear of any appliances; and cooperation in keeping appointments. Other precautions and recommendations may include, but are not necessarily limited to:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR THE PROPOSED TREATMENT, MEDICATION, OR SURGERY, DESCRIBED ABOVE. I ACCEPT THE RISKS OF SUBSTANTIAL HARM, IF ANY, IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULT OF THIS TREATMENT OR PROCEDURE. I FURTHER ACKNOWLEDGE THAT ALL BLANKS ON THIS FORM, REQUIRING COMPLETION, HAVE BEEN FILLED IN, OR DELETED IF NECESSARY, PRIOR TO MY SIGNING THIS FORM.

Witness _____ Patient _____