INFORMED CONSENT FOR PERIODONTAL THERAPY

DIAGNOSIS: After a careful oral evaluation and study of my dental condition, my clinician (dental student/periodontal resident/periodontist) has advised me that I have periodontal disease or another periodontal condition that has caused damage to the soft tissues and/or bone around my teeth and that may be endangering the health of my oral tissues. I understand that periodontal disease weakens support of my teeth by separating the gums from the teeth. The pockets caused from this separation allows for greater accumulation of bacteria under the gum in hard to clean areas and can result in further erosion or loss of gums and bone supporting the roots of my teeth. Other periodontal conditions may also result in loss of gums and bone around my teeth. If I have periodontal disease and do not receive treatment for it I understand that this disease is generally non-reversible and can be progressive leading to further damage and possible tooth loss. The periodontal condition that I have, requiring periodontal therapy, is the following:
_________________________________________________________________________________

RECOMMENDED PROCEDURES AND TREATMENT ALTERNATIVES: In order to treat this disease or condition my clinician has recommended the following periodontal therapy:

1. Non-surgical scaling/root planing, or cleaning (scraping) of my tooth root surfaces (mechanical debridement) in an effort to heal my gums from the damage resulting from the periodontal disease.

2. Medication(s), in an attempt to further reduce bacteria under the gum line - with the expectation that this may help reduce deep bacteria and tartar but may not reduce gum pockets.

3. Periodic periodontal maintenance therapy following 1 and/or 2 above.

4. Periodic periodontal maintenance therapy alone.

5. Extraction of teeth involved with periodontal disease.

6. No treatment - with the expectation of possible worsening of my disease or condition, which may result in premature tooth loss.

I understand that the treatment required for my periodontal disease or periodontal condition may not be limited to the treatment described above.

I understand that local anesthetics may be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

The treatment procedure(s) to be completed is (are):_____________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
PRINCIPAL RISKS AND COMPLICATIONS: I understand that a small percentage of patients do not respond successfully to therapy, may have the disease or condition of the gums get worse after therapy, and may lose teeth in spite of therapy. Patients exhibiting greater risk for failure of therapy are those who:

1. Do not comply with maintenance schedules,
2. Exhibit inadequate oral hygiene,
3. Smokers,
4. Drink alcohol,
5. Take certain medications,
6. Have dietary and nutritional problems,
7. Have certain medical problems.

Although complications from non-surgical periodontal therapy are rare, they can occur and may include, but are not limited to:

1. Post-treatment discomfort,
2. Bleeding,
3. Tooth sensitivity to hot, cold, sweets or acidic foods,
4. Shrinkage of the gums upon healing resulting in the appearance of elongation of some teeth and larger spaces between some teeth,

Signed: ________________________________  Date: ________________________________

PATIENT or Guardian

Signed: ________________________________  Date: ________________________________

Witness or Dr. Drake