Chart #

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For Treatment Plan Dated:

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INFORMED CONSENT FOR PROPHYLAXIS, GROSS SCALE, & DEEP SCALING

This is my consent for ___________________________ to perform the following treatment / procedure:
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I understand that the purpose of the procedure is to treat and possibly correct my diseased oral/ maxillofacial tissues. I have been advised that if this condition persists without treatment, my present oral condition will probably worsen in time and the risks to my health may include, but are not limited to, the following: swelling, pain, infection, cyst formation, malocclusion, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

The Doctor has explained to me that there are certain inherent and potential risks in any treatment or procedure (including the administration of any necessary local anesthesia) which include, but are not limited to:

A. Post-Operative discomfort and swelling that may persist for several days.
B. Stretching of the corners of the mouth with resultant cracking and bruising.
C. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several days, weeks, months, or in some instances, permanently.
D. Swelling, bruising, and bleeding of the gum tissue.
E. Shrinkage of the gum tissue.
F. Sensitivity of the teeth.
G. Loosening of the teeth.
H. Fracture of fillings and porcelain of previous crowns.
I. Exposure of margins of previous crowns or caps.

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 retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I understand that deep scaling is only the first step of periodontal (gum) therapy and that afterwards the doctor will reevaluate the condition of my gums to determine if any further treatment is indicated to be done either by the doctor or referred to a periodontist (gum specialist).

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

____
Patient or Parent

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Doctor

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Witness

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Date