I UNDERSTAND that dental treatment requiring PERIODONTAL THERAPY (SCALING AND ROOT PLANING,) which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) There are many variables that alter responses to periodontal therapy, making it impossible to precisely determine whether or not periodontal treatment will achieve the results desired by the attending dentist and hygienist. Should the desired results not be attained, additional periodontal therapy may need to be performed.

_____(initials) When receiving periodontal therapy, it is mandatory that you exercise extreme diligence in performing the home care required and instructed by the treating dentist and/or hygienist. Without the necessary home and follow-up care by you the patient, the probability of a successful result is greatly reduced.

_____(initials) Periodontal therapy may be followed by moderate to severe pain and soreness in the gums and bony tissues. Such pain and discomfort must be expected, and instructions will be given as to the methods of controlling pain and soreness.

_____(initials) Following periodontal therapy, light constant bleeding may occur. Some bruising and/or swelling of the intraoral and facial tissues may occur. If bleeding doesn't stop within an hour of treatment, it is your responsibility to contact the doctor.

_____(initials) Injury to adjacent teeth, fillings or porcelain crowns may occur no matter how carefully periodontal therapy procedures are performed. Fractured fillings or crowns may require replacement.

_____(initials) Because of the normal existence of bacteria in the oral cavity, the tissues of the heart in some cases, and due to a number of other unforeseen conditions, may be susceptible to bacterial infection transmitted from the mouth to the heart through the circulatory system. A condition called bacterial endocarditis (an infection of the heart) may occur which can result in damage to heart valves. If any heart problems are known or suspected (such as a heart murmur following rheumatic fever, existence of an artificial heart valve, cardiac damage following PhenFen use, etc.), the dentist must be informed prior to periodontal therapy.

_____(initials) Muscle or jaw soreness may be noticed following periodontal therapy. Pre-existing conditions affecting the jaw-joints (TMJ) may be aggravated by periodontal therapy. Clicking, popping, muscle soreness, and difficulty opening may be noticed for some time following surgery. If such symptoms or conditions persist, you, the patient, should call our office. The patient must notify the dentist of any such pre-existing conditions prior to periodontal therapy.

_____(initials) It may be necessary to retrieve a broken instrument surgically even though much care is extended to avoid such incidents. Post treatment infection may also result from calculus being lodged in the tissue which may also require surgical intervention.

_____(initials) Increased mobility (looseness) of the teeth during the healing period should be expected in many cases. Ultrasonic instrumentation is usually required to remove infection in your gums, but it is noisy and the water used may cause cold sensitivity during treatment on un-anesthetized teeth. Cracking or stretching of the lips/corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planning.

_____(initials) As a result of periodontal therapy, gum tissues may shrink or recede exposing the margins of crowns and bridges, creating an unaesthetic or unsightly appearance. In addition, spaces may be created between the teeth that were not there previously. It may be necessary to replace pre-existing crown and bridgework as a result of shrinkage and recession. Additionally, root surfaces may be exposed which increase the sensitivity of the teeth, which may also require additional procedures to treat.

_____(initials) Unusual reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It

is important to take all prescription drugs according to the doctor's instructions. If you are a female on oral contraceptives, you must be aware that antibiotics can render those contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during treatment.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warrantees have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date
Tooth Number(s)	Witness to Signature	Date
Healthcare Provider's Name	Signature of Healthcare Provider	Date

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