Discussion and Informed Consent for Nonsurgical Periodontal Treatment

Patient Name: _____ Date: _____

Diagnosis: _____

Quadrants: _____

Facts for Consideration

Patient's initials required

_____ An examination of your oral cavity includes measuring the pockets under the gums surrounding your teeth to determine if your gum condition requires treatment. Dental X-rays will be taken to check the condition of the bone that supports your teeth.

_____ In general, as bone is lost from the periodontium (the bone that is directly attached to the teeth), pocket depths increase and "deep pockets" generally form. This is significant because the bacteria can easily be harbored beneath the gums attached to the root of the teeth and cause continued bone loss. For this reason, the paramount therapy in periodontal treatment is to decrease the pocket depths. The shallower the pocket depths, the healthier the periodontium.

_____ Periodontal (gum) treatment is intended to remove the bacterial substance known as plaque, which is the principal cause of gum disease, and hard mineral deposits called calculus from above and below the gum line.

_____ The treatment involves *scaling*, which uses hand instruments to remove plaque and calculus from the tooth and root surfaces are then smoothed. Medications or a special mouth rinse can be used to help control the growth of bacteria and may be part of treatment.

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

_____ A topical or local anesthetic (numbing medication) may be administered just before treatment depending on the sensitivity of the area to be treated.

Benefits of Nonsurgical Periodontal Treatment, Not Limited to the Following:

_____ Regular, professional dental 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 Nonsurgical Periodontal Treatment, Not Limited to the Following:

_____ I understand that one of the effects of treatment is that my gums may bleed or swell and I may experience moderate discomfort after the anesthesia wears off. There may be soreness for a few days, which may be treated with pain medication. I will notify the office if conditions persist 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 that may require treatment with antibiotics or other therapies.

_____ 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, sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____ I understand that after treatment, 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 may be needed to treat the exposed areas.

_____ I understand that depending on my current dental condition, existing medical problems or medications I may be taking, these periodontal treatment 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 as part of my treatment. In rare instances, patients may have a reaction to the anesthetic, which could require emergency medical attention. **Because of the anesthesia, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury causing numbness or pain of the lip, chin, cheek, teeth or tongue may result from an injection.

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

_____ I understand that smoking can adversely affect the outcome of the periodontal therapy suggested and that final results of periodontal therapy may be minimal or negated because of my history or lack of smoking cessation.

_____ I understand that every reasonable effort will be made to ensure that my condition is treated properly, although it is not possible to guarantee results. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

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

_____ I understand that if no treatment is administered or ongoing treatment is interrupted or discontinued, my current periodontal condition may continue and is likely to get worse. This could lead to further inflammation and infection of gum tissues, tooth decay above and below the gum line, deterioration of bone surrounding the teeth and eventually the loss of teeth.

Alternatives to Nonsurgical Periodontal Treatment, Not Limited to the Following:

_____ I understand that surgical methods may also be necessary to help control my gum disease. I have discussed with my dentist 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.

Check the boxes below that apply to you:

Consent

☐ I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed protective stabilization.

☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr.. to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date