ADVANCED
Implants & Periodontics

Consent to Scaling and Root Planing

In order to treat my current periodontal condition, my doctor has recommended that my treatment may include scaling and root planing. I understand that local anesthetic will be administered to me as part of treatment, and that I have the option to choose sedation for relaxation during the procedure.

I have been informed and I understand the purpose and nature of the procedure I am about to receive. My doctor has carefully examined my mouth, and alternatives to this treatment have been explained. I have tried or considered these methods, but I desire this treatment option.

- □ I understand that a small number of patients do not respond successfully to scaling and root planning. In such cases, the involved teeth or implants may be lost. The procedure may not be successful in preserving and/ or achieving function or esthetics. Additional procedures may need to be performed if the initial results are not satisfactory. Each patient's condition is unique and long- term success may not occur. I understand that my medical/ health conditions, medications that I am taking, diet and nutritional problems, clenching of my teeth, excessive smoking, alcohol, or sugar may affect healing, and may limit the success of treatment.
- □ I understand that I may experience pain, swelling, infection, bruising, temporary or permanent numbness of the lip, tongue, chin, cheek or teeth, inflammation of vessels, injury to teeth, restricted mouth mobility, gum recession (shrinkage), interference with speech, severe tooth sensitivity (temporary or permanent).
- □ I understand that without treatment any of the following could occur: bone disease, loss of bone, gum tissue inflammation, sensitivity, looseness of teeth, tooth loss.
- □ I understand a re-evaluation appointment six weeks after my procedure is necessary to monitor my progress.
- □ It has been explained to me that the long-term success of treatment requires my cooperation and performance of plaque control (home care) as instructed at least twice a day, as well as recommended periodic periodontal maintenance visits to the office.
- □ I understand that the medications and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing my health care provider of a suspected or confirmed pregnancy. For the same reason I understand that I must inform if I am a nursing mother. Local anesthetic containing epinephrine (lidocaine) is considered a class B drug, and is approved for use in pregnancy according to the American Dental Association. However, long term studies have not been performed.
- □ Other:_____

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Patient Name (please print): _____

Patient Signature:_____Date: _____

Witness Signature:_____Date: _____