

CONSENT TO PERIODONTAL TREATMENT

1. _____ I, the undersigned, hereby authorize and request Dr. _____ to perform the following procedure(s) upon me:

2. _____ I consent to all of the above procedure(s), as well as the performance of additional alternative procedures which in the judgment of Dr. _____ may be necessary to preserve my overall dental health. This includes the use of donor bone if found to be necessary to treat my periodontal condition.

3. _____ I also authorize and request the administration of anesthesia as may be deemed advisable by Dr. _____.

4. _____ It has been explained to me, and I understand that conditions such as smoking, inadequate oral hygiene and plaque control, inadequate recall and maintenance visits, and occlusal trauma (i.e. clenching and bruxing) increase greatly the risk of the reoccurrence of periodontal disease and its associated symptoms.

5. _____ It has been explained to me, and I understand that success of the aforesaid procedure(s) and treatment is not guaranteed or warranted and, in addition, I understand that such success cannot be guaranteed or warranted.

6. _____ If alternative treatment methods to the procedure(s) above described are available to treat the aforesaid dental disorder in my case, they were fully described to me prior to the time I executed this consent to dental treatment, as witnessed by my signature and the date below.

7. _____ When implant therapy is performed, I have been informed that the cost of the restorative therapy will be my responsibility to the restoring doctor.

8. _____ When gingival grafting procedures are performed, I have been informed that the amount of root coverage is unpredictable.

9. _____ Finally, such risks and complications as may ultimately develop and/or immediately follow upon the mentioned procedure(s) and administration of the anesthetics have been fully explained to me, including, but not limited to: recession, sensitivity, bleeding, swelling, infection, paresthesia (numbness), sinus involvement, temporomandibular muscle and joint pain, tooth fracture, and unfavorable reactions to drugs and anesthetics including, but not limited to, nausea, vomiting, hallucinations, "feeling out of control", and allergic reactions.

PATIENT SIGNATURE

DATE

DOCTOR SIGNATURE

DATE