

# Scituate Periodontics

## CONSENT TO PERIODONTAL (GUM) TREATMENT

I hereby authorize Doctor Hassan, and whomever he designates as his assistant(s), to perform the following treatment upon \_\_\_\_\_.  
(patient's name)

### DIAGNOSIS

I have been informed that I have Periodontal (gum) Disease and/or deformities that could lead to the loss of certain teeth. I have been advised that the proposed therapy is intended to extend the life expectancy of my teeth. This consent form outlines that treatment program, its expected consequences and limitations.

### TREATMENT PROCEDURES

- \_\_\_ Oral hygiene instructions
- \_\_\_ Polishing and scaling
- \_\_\_ The administration of anesthetic agents topically and by injection
- \_\_\_ Root planning and curettage
- \_\_\_ Localized antibiotic therapy
- \_\_\_ Chemical pocket irrigation
- \_\_\_ Biopsy of tissues for microscopic evaluation
- \_\_\_ Occlusal/bite adjustments
- \_\_\_ Temporary tooth splinting
- \_\_\_ Bite guard/ snoring appliance/clenching grinding guard
- \_\_\_ Extraction of teeth or root as determined during surgery
- \_\_\_ Root desensitization therapy
- \_\_\_ Periodontal maintenance therapy
- \_\_\_ Surgical periodontal treatment: \_\_\_\_\_

### ALTERNATIVES

Further, I have been informed that possible alternatives to the above treatment include:

- maintenance therapy only
- root planning and maintenance therapy only
- extractions

We have discussed, however, that the procedures first recommended should be performed due to the improved prognosis.

### NON-TREATMENT RISK

I further understand that if no treatment is rendered the risk to my dental health includes, but is not limited to, the following:

- premature loss of teeth
- gum recession
- halitosis (bad breath)
- loosening of teeth
- Abscesses (gum boils)
- tooth drifting, flaring or other tooth movement
- further deepening of periodontal and/or pus pocket
- further loss of bone

**TREATMENT RISKS**

Risks of the treatment include, but are not limited to:

- allergic or other reactions to medications and local anesthesia
- swelling/discomfort
- thermal (hot/cold/sweets) sensitivity
- exposure of margins of crowns (caps) and/or root surfaces
- phonetic (speech) interference
- infection
- tooth mobility
- food impacting between teeth
- temporary restricted mouth opening
- numbness of jaw or gum nerves
- delayed or inadequate healing
- gum shrinkage
- spaces between teeth
- esthetic changes
- tooth loss despite therapy
- other \_\_\_\_\_

**NO WARRANTY**

No guarantee, warranty, 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, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require re-treatment and/or extraction of teeth. However, it is the Doctor’s opinion that therapy will be helpful, and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.

It has been explained to me that the long term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment at a dental office. I have been fully informed of the nature of periodontal treatment, the procedure to be utilized, the risks and benefits of periodontal treatment, the alternative treatments available, and the necessity for follow-up and self- care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist.

**INFORMED CONSENT**

After thorough deliberation, I hereby consent to the performance of periodontal treatment as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I certify that I have read and fully understood this document.

\_\_\_\_\_  
Please print/sign: patient name, parent or guardian

\_\_\_\_\_  
Date