CONSENT TO PERIODONTAL TREATMENT

Patient Name:_____ **Date:**_____

This consent and authorization is given to Dr. Les Wong, hereafter referred to as Doctor, after having first had a full explanation of the nature of the proposed treatment, the alternatives, and the risks. Doctor has advised me that the nature of my dental condition is:_____

_____

I hereby consent and authorize Doctor and whomever he may designate to do the following procedure(s):

____Scaling and Root Planing followed by a Periodontal Reevaluation.

____Periodontal Surgery involving the use of donor membrane from a tissue bank.

____Periodontal Surgery involving the use of a secondary surgical site, usually the roof of the mouth.

____Pinhole Surgical Technique which would utilize collagen membrane.

____Anti-bruxism device

This information is based on recommendations by the American Dental Association and is used in this office for the purpose of assisting you in choosing the best dental treatment alternative(s). It further informs you of the critical part you must play in keeping your teeth and gums healthy.

Alternative Treatment: Return every 90 days to have basic Periodontal Maintenance cleaning, extraction, consultation with a periodontist, or no treatment.

Risk of No Treatment: May include but is not limited to premature tooth loss, a need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, abscesses or infections, pain, poor chewing ability, tooth sensitivity, worsening of the periodontal condition, tooth extrusion, tooth crowding, teeth spreading apart, secondary infection to other parts of the body, malocclusion (bad bite), jaw joint pain, speech difficulties, increased vulnerability to decay and erosion of exposed root surfaces, and others.

Treatment Risks: Inherent to any procedure and because of individual variation, various risks are involved with treatment. Risk may include but are not limited to swelling, pain, hot/cold sensitivity of the teeth, gum recession, dark triangles and gum shrinkage may emerge between teeth, increased tooth mobility, gum infection, gum abscesses, tooth abscesses, exposure of crown margins or edges, speaking difficulties, food impaction, root staining, oral opening restrictions, tissue sloughing, continued periodontal disease, rejection of membrane material, jaw joint pain or disorder, prolonged bleeding, instrument breakage, untoward reaction to local anesthetics, neck strain, tongue or chhek biting due to numbness, changes in the bite, generalized infection, secondary infection to other pars of the body, debris into the eyes, loosening of fillings or crowns, temporary or permanent nerve numbness, inadvertent swallowing of loosened fillings or crowns, drug reactions, allergies, and other.

Patient Initials_____

I understand that the proposed treatment contains no guarantee or warranty of success. Each individual case is unpredictable, making it impossible to surmise the exact results. I fully understand that the results may not be to my complete and full satisfaction after the treatment, and that my condition may be the same, better, or worse following treatment.

If I have or develop any medical conditions such as mitral valve prolapse, artificial joints, or rheumatic fever or any other conditions requiring pre-medication with antibiotics, it will be my responsibility to take said antibiotics according to my physician's instructions. If I do not take the pre-medication as prescribed, I shall call such error to the attention of the doctor.

I understand that for successful periodontal results and to lessen the dangers of complications, I must maintain excellent oral hygiene, proper diet with restriction of hard or chewy foods, wearing of any prescribed occlusal appliances, and cooperation in keeping appointments. I further acknowledge that even though periodontal treatment may be successful, relapse and future deterioration of the periodontal condition may occur as a result of poor oral hygiene, lack of regular follow-up care, adverse systemic conditions such as diabetes, and dry mouth. If such deterioration occurs, I understand that further treatment with its attendant risks may be necessary.

It has been explained to me that periodontal care will not be successful without the proper restoration of remaining teeth and the replacement of missing teeth. Although the treatment of gum conditions should come first, I understand I must follow through on a timely manner with restorative and prosthetic dental treatment to keep my gums in a healthy state. I have agreed to return for follow-up gum care at regular intervals of every 3 months.

I have received a full and complete opportunity to ask any questions about the proposed treatment. All my questions have been answered to my complete satisfaction before I signed this consent form.

I certify that I have read and understand the authorization that I am about to sign for the proposed treatment, medication(s), and surgical procedure. I accept the risks of substantial harms, if any, in hopes of obtaining the desired beneficial results of this treatment. I further acknowledge that all blanks in this form requiring completion have been filled in or deleted if necessary, prior to my signing this authorization.

Patient Signature_____ Date_____

Doctor Signature_____ Date_____