AS4U0716 -EXPLANATION OF LASER TREATMENT:CONSENT FORM

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Explanation of Laser Treatment and Consent Form

I hereby authorize Dr. and staff to perform upon me the following treatment and procedures:
Laser treatment on Area(s):

The following treatment was explained by the doctor/staff and includes:

_____

-It is important that you understand the following information: The goal of the laser procedures we use is to eliminate or remove gum tissue to either improve the appearance of the smile or gain access to a tooth that has not erupted. The laser treatment results in improvement in the intended condition.

Alternatives:
There are alternatives to using the dental laser. Those could include more conventional scalpel surgery in the office of another dental professional at an additional fee. Frequently those procedures will involve sedation which may be helpful in a very apprehensive patient. If you would rather pursue an alternative treatment, please let your doctor know and he would be happy to discuss those alternatives with you.

Possible Short-Term Effects of Laser Dental Treatment:
1. Pain or a burning/itching sensation may occur for a few days after treatment. A topical anesthetic and occasionallya local anesthetic will be used to block discomfort during the procedure but you may still notice discomfort during the procedure. Let the doctor know and he can administer more anesthetic. The numbing effects of the anesthetic may continue to be felt after the procedure.
2. Redness/Inflammation/Swelling of the tissue will likely be noticed for the first few days. The tissue surrounding thesight of the procedure may feel “tight”.
3. Wound Healing – Oozing of the tissue in the treated area will usually persist for a short time.
5. You may have a recurrence of a “fever blister.”

Possible Long-Term Complications of Laser Dental Treatment:
1. Scarring – The risk of scarring exists. It is variable and often related to genetic makeup. It can be minimized bycarefully following appropriate aftercare instructions.
2. Tissue Pigment Changes – Soft tissue color and texture changes may occur. At the junction of treated anduntreated areas, a difference in color, texture, and/or thickness may appear.
3. Infection – There is a risk of infection common to all surgical procedures. It can be minimized by proper postoperative care.

Anesthetics Employed: We will be using a topical anesthetic either alone or occasionally in combination with an injected local anesthetic.

1. The patient must be careful to avoid biting or chewing on the tongue, lip, cheek, or other parts of the mouth whenthey are numb.
2. The anesthetic may make swallowing seem more difficult though the sensation will improve after the effect wearsoff.
3. Let the doctor know if you have ever had an allergic reaction to anesthetics used in a dental office.
4. Let the doctor know if you are or suspect you are pregnant or are breastfeeding.

Patient Consent:
I understand that:
1. Any application of excess heat to the treated area must be avoided for 2-3 days to minimize bleeding and promotehealing
2. This is an elective procedure and the treatment is not reversible.
3. More procedures may be needed to achieve the optimal obtainable result.

CHANGES IN TREATMENT:
I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions necessary.

I understand this explanation of laser dental surgery and its risks, benefits, and alternatives. I therefore give consent to having the laser dental surgery.

I have read the above statements and have received a copy (if requested), and recognize their importance in helping me with making my decisions. My signature indicates that I have read and understand this consent document.

I recognize that failures can occur for various reasons and complications can occur in any procedure. I hereby grant authority to the doctor in charge to administer such procedures that may be deemed necessary or advisable in the diagnosis and/or treatment. I also certify that the information I submitted in the health questionnaire is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending doctor and me, I will give that doctor the opportunity to resolve the problem.

The risks and benefits associated with the above-referenced dental treatment have been thoroughly explained to me. I understand there is no certainty that I will achieve the desired benefits and/or results, and no guarantee or assurance has been made to me regarding the outcome of such dental treatment. In authorizing the abovereferenced dental treatment to be performed, I understand that unforeseen conditions may occur during such treatment, which may necessitate a total change, extension or modification of the original treatment outlined above, or necessitate a different type of treatment than such authorized treatment set forth above. I therefore authorize and request that such treatment may be necessary and desirable in the exercise of my doctor’s professional judgment.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extraction(s), I agree to report them to the office as soon as possible. In case of an acute emergency, and in the event you cannot reach this office, or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

Furthermore, I have been fully informed as to the nature of my dental treatment including other such care and treatment, along with the potential benefits, risks or side effects of such dental treatment, and the likelihood of achieving the desired results. I have been told that the success of the dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I have discussed all of the above with the doctor, and have had all of my questions answered to my satisfaction. I consent to treatment.

Signature of Patient, Parent, or Guardian _____