AS4U0716- PERIODONTAL THERAPY TREATMENT

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INFORMED CONSENT FOR PERIODONTAL THERAPY TREATMENT

Hygienist:
Treatment: FMD, SRP, or PERIO MAINTENANCE:

OBJECTIVE: The purpose of our soft tissue management (STM) program is to remove hard and soft deposits from the teeth and gum line and to decrease inflammation. Your gums are not healthy and this is a therapeutic treatment to restore health when combined with proper and effective homecare. After completion of our STM program, periodontal surgery may be recommend after re-evaluation, in order to eliminate periodontal pockets.

Benefits:
Healthy Gums & Teeth
Clean Mouth
Reduces Bad Breath
Stabilize Gum Disease

Possible Complications:
Sensitive Teeth & Gums
Feeling of Spaces between Teeth
Filling may be loosened–normal if filling was ready to fall out

Postponing Treatment:
Stains on Teeth
Mouth Odors
Gum Disease
Will Lose Teeth sooner

STAGE I - FULL MOUTH DEBRIDEMENT (FMD)

4355 FMD
0180 Periodontal Evaluation
0274 BWX-X-rays
Chlorhexidine or Perio Med

STAGE II – SCALING & ROOT PLANING (SRP)

4341 4 or more teeth per quad U/R U/L L/R L/L
4342 1 – 3 teeth per quad U/R U/L L/R L/L
4346 Scaling Generalized Moderate/Severe Gingival Inflammation - FM

9630 Medicinal irrigation with Chlorhexidine U/R U/L L/R L/L
4381 Locally administrated antibiotic therapy (Arestin) Teeth #'s:

STAGE III – PERIODONTAL MAINTENANCE

4910 Periodontal maintenance

LOCAL ANESTHETIC

Lidocaine, Septocaine, or Carbocaine

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 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.

I understand my condition, the treatment required and I accept treatment.

Patient Parent/Legal Guardian Signature: _____