

INFORMATIONAL PURPOSES ONLY

PERIODONTAL PROCEDURES
SCALING AND ROOT PLANING

I UNDERSTAND that PERIODONTAL PROCEDURES (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions through scaling and root planing and related procedures, there are no promises or guarantees as to anticipated results. I agree to assume those risks and possible unsuccessful results associated with, but not limited to, the following:

- Response to treatment:** Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by both Dr. _____ and the patient. Should the desired results not be attained, extractions may be required.
- Postoperative patient responsibility for care:** With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist. Without the necessary follow-up care by the patient, the probability of unsatisfactory results is greatly increased.
- Pain, soreness and sensitivity:** There may be post-operative discomfort which may be transitory or permanent, related to hot and cold stimuli, contact with teeth, and sweet and sour foods. The gums will also be sore immediately following treatment.
- Bleeding during or after treatment:** Laceration or tearing of the gums may occur which might require suturing. The gums may bleed as well during or after treatment.
- Recession of the gums after treatment:** After healing occurs, there may be gum recession which exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, creates esthetic or cosmetic changes in front teeth which results in longer teeth and wider interproximal spaces visible as a black triangle. These wider interproximal spaces are more likely to trap food.
- Broken curettes, scalers or other instruments, and post-treatment infection:** It may be necessary to retrieve broken instruments surgically. Post treatment infection may also result from calculus being lodged in the tissue which may also require surgical intervention.
- Increased mobility (looseness) of the teeth during the healing period.**
- Noise and water spray:** Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on unanesthetized teeth not in the treatment field.
- Post-treatment complications:** Cracking or stretching of the lips/corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planing.
- Sequela of local drug delivery:** If tetracycline fiber is used, there may be premature loss of the fibers necessitating a return visit to the dental office for replacement. There may be soreness or pain in the treated areas. The patient will be aware of the adhesive sealer, which often has granular surface. The sealer has an opaque or milky appearance and may be visible. There will be a need for a post-op visit to remove the fibers seven to ten days after placement. There may be an adverse reaction to the antibiotic in the fiber whether a re-existing, known allergy exists or not.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's name (please print)

Signature of patient, legal guardian
or authorized representative

Date

Witness to signature

Date