CONSENT TO PERIODONTAL (GUM) TREATMENT

I, _____, (on behalf of _____) hereby authorize Pamela K. McClain, D.D.S. and/or Rachel A. Schallhorn, D.D.S. (herein after called "Doctor"), and whomever they may designate as their assistant(s), to perform the following treatment and/or surgery:

DIAGNOSIS

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

TREATMENT PROCEDURES

* Oral hygiene/disease prevention
* Microscopic assessment of subgingival scrapings
* Chemical pocket irrigation and/or placement of subgingival medication
* Biopsy of tissues for microscopic evaluation
* Polishing and scaling of teeth and/or implants
* The administration of anesthetic agents topically and by injection
* Root planing and/or curettage (tooth and/or gum scraping)
* Occlusal/bite adjustment
* Tooth straightening procedures with fixed and/or removable appliance(s)
* Temporary splinting
* Biteguard
* Periodontal surgery (gingivoplasty; flap surgery with/without osseous contouring; osseous/alloplastic and/or bone bank grafts; soft tissue grafts; frenulectomy; stomatoplasty; fiberotomy; placement of special membranes for guided tissue regeneration; exostosis reduction/removal)
* Ridge augmentation
* Extraction of teeth or roots as determined during surgery
* Root desensitization therapy
* Nitrous Oxide, oral premedication and/or intravenous sedation
* Periodontal maintenance therapy (professional recall care)
* Placement, repair or removal of dental implants

ALTERNATIVES

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

* Maintenance therapy only
* Root planing/curettage and maintenance therapy only
* Pre-surgical and maintenance therapy only
* Extraction(s)
* Other _____

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

NON-TREATMENT RISKS

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

* Premature loss of teeth
* Gum recession
* Halitosis
* Loosening of teeth
* Abscesses (gum boils)
* Tooth drifting, flaring or other tooth movement
* Further deepening of periodontal and/or pus pockets

TREATMENT RISKS

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

* Allergic or other reactions to medications and anesthesia
* Swelling
* Pain
* Thermal sensitivity
* Exposure of margins of crown (caps) and/or root surfaces
* Phonetic interferences
* Infection
* Tooth mobility
* Food impaction and spaces between teeth
* Temporary restricted mouth opening
* Numbness of jaw or gum nerves
* Root resorption
* Other

_____

_____

CONSENT TO UNFORESEEN CONDITIONS DURING SURGERY

If any unforeseen condition should arise in the course of the operation, calling for the Doctor's judgment for procedures in addition to or different from those contemplated, I further request and authorize the Doctor to do whatever he/she/they may deem advisable.

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PRE- AND POST-OPERATIVE INSTRUCTIONS

Because of the nature of the proposed treatment and/or procedure, Doctor has advised me,* that if I am to have relaxation premedication I * should have nothing to eat or drink after midnight the night before or within 4 hours of the proposed surgery. Additionally, certain prescribed medication may cause drowsiness, alone or in combination with alcohol or other sedatives. I *, have been advised not to drive or operate dangerous machinery within 24 hours of taking such medication. Accordingly, I *, have arranged to be driven and accompanied home by another person.

PHOTOGRAPHS - OBSERVERS

In furtherance of the progression of dentistry and the dental health of the public, I do hereby consent to photographs being taken and subsequent publication solely for educational and scientific purposes, and to having health professional observers in the examination and/or treatment room for educational purposes.

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 retreatment and/or extraction of teeth. However, it is 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 CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL OF MY QUESTIONS ANSWERED SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT, THE EXPLANATION THEREIN REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE SECTIONS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

DATE_____**SIGNED**_____

PATIENT OR LEGAL GUARDIAN

_____

RELATIONSHIP TO PATIENT

_____

WITNESS

*On behalf of the patient if signed by the legal guardian