Healthy Smiles Dental

Informed Consent
Periodontal Scaling and Root Planing

I understand that I have periodontal (gum and bone) disease. The disease process has been explained to me and I understand that it is caused by bacterial toxins (poisons) and my host response to these toxins. I realize that this disease may be painless and symptomless, but that usually symptoms such as bleeding, swelling, or recession of gum tissue, loosened teeth, elongated teeth, bad breath, or sensitivity and soreness may be noticed. Treatment of periodontal disease may include periodontal scaling and root planning, either as a therapeutic *procedure* or preliminary to more extensive treatment.

Periodontal scaling and root planning involves the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum (the outer covering of the root surface) and diseased tissue from the inner lining of the crevice surrounding the teeth. The purpose of this procedure is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. I understand that my *own* efforts with home care are just as important as my professional treatment.

Consequences of doing nothing about my periodontal condition may be, but are not limited to:

- Worsening of the disease with increased bone loss and possible eventual tooth loss
- Increased infection, systemic problems, bleeding, pain, and soreness

Treatment risks may be, but are not limited to:

- Increased recession of gum tissue and exposure of root surfaces (as tissue heals, swelling decreases).
- Increased sensitivity to hot, cold, or sweets. This may require further treatment, may fade with time, or may persist no matter what is done.
- Exposed roots may acquire stain more readily.
- Food may collect between teeth. Proper cleaning techniques will be explained in detail.
- If teeth were loose prior to procedure, they may seem more loose immediately after. Usually after healing, teeth "tighten."
- Some pain, swelling, or bruising may be experienced after treatment.

I understand the recommended treatment; the risks of such treatment and any alternative treatment and risks have been explained to me. I understand the fee(s) involved in the treatment as well as consequences of doing nothing.

_____ _____

Name of Patient Signature of Patient

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Date

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