



## PERIODONTAL SCALING AND ROOT PLANING INFORMED CONSENT

This form and your discussion with your doctor are intended to help you make an informed decision about your procedure. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. In order to increase the chance of achieving optimal results, you have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable). Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

I have been informed of and understand the potential risks related to this procedure include but are not limited to:

- Varying lengths and degrees of sensitivity, bleeding, infection, gum irritation, increased spacing between teeth due to removal of hard deposits, revealing of recessed gums, cracking or stretching of the lips or corners of the mouth, increased mobility of teeth, allergic and/or adverse reaction to medications and/or materials

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials, pain at the anesthesia injection site, bruising/swelling, nerve injury, nausea, vomiting, disorientation, confusion, lack of coordination, drowsiness, heart and breathing complications, numbness following anesthesia that in rare instances may be permanent, overdose.

It has been explained to me that the purpose of this therapy is to reduce some of the causes of my periodontal disease. I understand that my condition may require additional treatment that may include additional "deep cleanings", periodontal surgery, and/or antibiotics.

### Patient's Responsibilities

I understand the use of tobacco and alcohol is detrimental to the success of my treatment. I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results. I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Date