CONSENT FOR PERIODONTAL THERAPY/SCALING AND ROOT PLANING (DEEP CLEANING)

I understand that I have been diagnosed with periodontitis/periodontal disease, requiring scaling and root planing (deep cleaning) to treat the gum and bone supporting existing teeth. Even though the disease process may be painless, the signs and symptoms of the disease include bleeding, swelling and redness of the gums, recession of gum tissue, elongated teeth, loosening or movement of the teeth, bad breath, and sensitivity or soreness. Periodontal therapy is required due to periodontal pockets, the presence of infection, and/or the loss of bone support to the teeth.

I understand that the goal of a deep cleaning is to reduce or eliminate these pockets, remove unhealthy tissue, remove calculus/tartar, remove bacterial plaque, and thoroughly clean the root surfaces of teeth. Even with a deep cleaning, periodontitis may persist or worsen with time, and teeth could be lost in the future due to external factors (i.e. advanced or aggressive periodontitis, lack of adequate home care, nutritional or hormonal factors, etc.).

Even though care and diligence will be exercised by my treating dentist, there are inherent risks associated with any procedure. I agree to assume those risks, including possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. **Post-op Discomfort**: There may be pain and/or sensitivity to the teeth following treatment. This discomfort may be temporary or permanent, related to hot and cold stimuli, contact with teeth, and sweet and sour foods. The gums may also be sore immediately following treatment. Cracking or stretching of the lips/corners of the mouth during treatment is possible. There is a possibility that additional treatment may be necessary after root planing, which will be determined upon reevaluation after an appropriate healing period.

2. **Bleeding & Recession of Gums**: The gums may bleed during or after treatment due to the periodontal disease. Additionally, laceration or tearing of the gums may occur, which may require suturing. After healing occurs and swelling goes down, there may be gum recession which exposes the margin or edge of crowns, bridges, or fillings. This can lead to sensitivity of teeth and create aesthetic/cosmetic changes in front teeth which results in longer teeth and wider interproximal spaces visible as black triangles; these wider spaces are more likely to trap food and exposed roots may acquire stain more readily.

3. **Mobility (looseness) of teeth**: During the healing process, teeth may become loose. If teeth were loose prior to the procedure, they may seem looser immediately after. However, after healing, teeth usually “tighten.”

4. **Response to treatment**: Because of many variables within each patient’s physiological make-up, it is impossible to predict whether or not the healing process will achieve the results desired by both the doctor and the patient; should the desired results not be attained, referral to a specialist or extractions may be required.

Initials____

5. **Noise and water spray**: Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on un-anesthetized teeth not in the treatment field. It is dependent on the patient to inform the dentist or hygienist of any discomfort during treatment.

6. **Broken instruments and post-operative Infection**: It may be necessary to retrieve broken instruments surgically. Post-treatment infection may also result from calculus being dislodged in the tissue, which may also require surgical intervention.

PATIENT RESPONSIBILITY: The proper management of periodontitis and success of treatment is dependent on continued plaque removal (daily home care) and requires patients to attend future appointments for periodic maintenance cleanings and checkups. It is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist/hygienist. If periodontal disease progresses to the point requiring a specialist, it is dependent on the patient to schedule, attend, and pay for services provided by the specialist.

If oral antibiotics are prescribed, women on oral contraceptives must be aware that antibiotics may cause these contraceptives to be ineffective and other methods of contraception must be utilized during the treatment period.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal therapy, and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any. No guarantees or promises have been made to me concerning the results of treatment to be rendered to me. The fees 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 the doctors and hygienists at Thrive Dental & Orthodontics to render any treatment necessary or advisable to mine or my dependent's dental conditions.

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Patient's Name (please print)

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Signature of Patient, Legal Guardian, or Authorized Representative Date

_____ _____

Witness' Signature Date