CONSENT FOR ARESTIN

I hereby authorize the doctors at Thrive Dental & Orthodontics, along with their staff, to place Arestin for me or my dependent on tooth number(s):_____

I understand that Arestin is a Tetracycline based antibiotic placed directly under the gum where disease and infection have caused damage to the bone, ligaments, and the supporting structures of the tooth. Arestin is used as an adjunct to scaling and root planing (SRP) procedures to reduce pocket depths in patients with adult periodontitis, and is part of a "periodontal maintenance program" which includes deep cleanings and good at-home oral hygiene care. Even though care and diligence will be exercised by my treating dentist and hygienist, 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. **Pregnant & Nursing:** Tetracycline drugs should not be given to pregnant or nursing mothers.
PLEASE INFORM THE OFFICE IF YOU ARE PREGNANT, MAY BE PREGNANT, AND/OR ARE CURRENTLY NURSING.

2. **Unusual reaction to medications:** Reactions, either mild or severe, may possibly occur from anesthetic or other medications administered or prescribed. This product should not be used on patients who have a known sensitivity to minocycline or Tetracyclines. Hypersensitivity reactions include, but are not limited to: anaphylaxis, rash, hives, itchy skin, swelling of the face, and angioneurotic edema (swelling, similar to hives, beneath the skin).

Initials____

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of Arestin, 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.

_____

Patient's Name (please print)

_____ _____

Signature of Patient, Legal Guardian, or Authorized Representative Date

_____ _____

Witness' Signature Date