Consent for: Dental Hygiene

1) **T**he following informed consent form for dental hygiene treatment for the condition(s) described as: **gingivitis (inflammation (plaque/calculus around your gums, redness, some bleeding) of your "gum" tissues)** or **gingivitis and localized early chronic periodontal disease (inflammation of your "gum" tissues and some bone loss)**
2) The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be: **adult prophy (cleaning) or adult prophy and localized scaling and root planning** (cleaning including some area under your "gums")
3) The prognosis for this(these) procedure(s) was described as either: **good (unless otherwise indicated by the Dentist once your condition is evaluated)**
4) I have been informed of possible alternative methods of treatment including:
   - **A.** No treatment at all
   - **B.** _____
5) I consent to the administration of local anesthesia in connection with the procedure(s) referred above, if necessary. I understand that administration of local anesthesia involves risks including pain, paralysis, injury and rarely, even death.
6) Complications with local anesthesia although rare can include swelling, bruising, pain, infection, nerve damage, and unexpected allergic reaction, which could lead to a heart attack, stroke, brain damage and/or death.
7) Complications resulting from dental hygiene procedures (dental prophylaxis – scaling) and topical fluoride treatment include, but are not limited to, the following:
   - **A. Bleeding during or after treatment:** Laceration or tearing of the gums may occur which might require suturing. The gums may bleed as well during or after treatment.
   - **B. Pain, soreness and sensitivity:** There may be post-operative discomfort which may be transitory or permanent, related to hot and cold stimuli, contact with teeth, and sweet or sour foods. The gums will also be sore immediately following treatment.
   - **C. Recession of the gums after treatment:** After healing occurs, there may be gum recession which exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, creates esthetic or cosmetic changes in front teeth which results in longer teeth and wider interproximal spaces visible as a black triangle. These wider interproximal spaces are more likely to trap food.
   - **D. Broken curettes, scalers, or other instruments, and post-treatment infection:** It may be necessary to retrieve broken instruments surgically. Post treatment infection may also result from calculus being lodged in the tissue which may also require surgical intervention.
   - **E. Restorations:** May be removal of loose or broken restoration (fillings) or crowns.
   - **F. Soft tissue reactions to fluoride:** May be redness of the tissue, nausea if swallowed and temporary sloughing of mucosal tissue.
   - **G. Noise and Water spray:** Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on unanesthetized teeth not in the treatment field.
   - **H. Mobility:** Increase mobility of the teeth during the healing period.
   - **I. I acknowledge that it is my responsibility to seek attention should any undue problems occur after treatment. I shall diligently follow any preoperative and postoperative instructions given to me.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of having a dental hygiene procedure performed and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning desired results of this procedure. The fee(s) for this service have been explained to me and are 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 Dr. Lee and/or any associates to render that treatment necessary or advisable to my dental conditions, including the administration and/or prescribing of any and all anesthetics and/or medications.