Patient Initial

DISCUSSION & CONSENT FOR PERIODONTAL TREATMENT

Patient's Name: ____ Date of Birth: ________________________

Nature of Treatment

It has been recommended that I have the following periodontal treatment (all that apply have been checked for me):

□ Scaling and root planing □ Osseous (bone) surgery and recontouring □ Gingivectomy (gum recontouring)
□ Periodontal bone graft □ Soft tissue graft □ Referral to a gum specialist (periodontist)
□ Other: ____

Teeth or areas of each recommended treatment: ____

This recommendation is based on visual examination, periodontal probing and charting, X-rays, other diagnostic tests, any models or photos taken, and on my doctor's knowledge of my medical and dental history.

The treatment is necessary because of periodontal (gum) disease that has been diagnosed as:
□ Generalized chronic periodontitis □ Localized chronic periodontitis □ Gingivitis/gingival disease
□ Generalized aggressive periodontitis □ Localized aggressive periodontitis □ Other (as specified): ____________

Teeth or area that applies to each diagnosis: ____

I have been informed that periodontal diseases are infections that affect the tissues and bone that support teeth. I have been informed that other factors can affect my periodontal disease and its progression, including the condition of my dental restorations, certain diseases (such as diabetes and heart disease), habits (tobacco use), and medications.

Factors specifically affecting me include: ____

The intended benefit of this treatment is to improve the health of my gums and teeth and to try to retain my natural teeth as long as possible. Other benefits may include: ____

The prognosis, or likelihood of success, of this treatment is: _________________________
My treatment is estimated to take________ visits to complete, and is estimated to cost $_______________

Alternative Treatments: The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative ways to treat my periodontal dental condition include: _____________________________
□ No other reasonable treatment option exists for my condition.

Risks of the Recommended Periodontal Treatment: I understand that no dental treatment is completely risk-free and that my dentist would take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include tooth sensitivity, pain from treatment, infection, swelling, dark spaces between teeth where there is no longer any gum tissue, and changes in how long my

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teeth appear (due to recontouring). I understand that as the health of my gum tissue improves, the tissues may shrink or recede: this is a normal reaction to treatment. This change may make some previous dental restorations (crowns, fillings) more noticeable and they may need to be replaced to make them more cosmetically acceptable. I understand that I may be given a local anesthetic injection and that in rare situations, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection.
Other risks of my treatment include: ____

Risks of Not Having the Recommended Periodontal Treatment:

I understand that complications to my teeth, mouth, and/or general health may occur if I do not proceed with the recommended treatment. These complications may include:
□ Pain □ Bleeding □ Swelling □ Mouth odor □ Tooth mobility □ Tooth loss □ Additional infection
□ Complication of other health issues (such as diabetes, heart disease, stroke)
□ Inability to proceed with other dental care

I have received information about the proposed periodontal treatment. I have discussed my treatment with Dr. Jaiswal and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I wish to proceed with the recommended periodontal treatment.

I understand this treatment can also be performed by a periodontist (a specialist in the treatment of periodontal disease). I understand the risks and elect to have this procedure performed by Dr. Beverly Jaiswal, DMD . I understand that if any unexpected difficulties occur during treatment, I may be referred to a periodontist for further care.

_______________________________	____________________	____________________
Patient or Guardian Signature	***Date***	***Time***
_______________________________	____________________	____________________
Treating Dentist Signature	***Date***	***Time***
_______________________________	____________________	____________________
Witness Signature	***Date***	***Time***