Informed Consent for Scaling and Root Planing (Deep Cleaning)

Diagnosis

After careful examination, the Doctor has informed me that I have periodontal disease in all or some areas of my mouth. I understand that periodontal disease weakens the support of my teeth by separating the gum from the teeth and destroying some of the bone that supports the tooth roots. I have been made aware of the fact that if left untreated, periodontal disease can cause me to lose my teeth and I can have other adverse consequences to my general health.

Recommended Treatment

In order to treat my periodontal condition, the Doctor has recommended that my treatment include scaling and root planing with local anesthetic. The purpose of this therapy is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. I understand that my condition may require additional treatment that may include a second deep cleaning, periodontal surgery, or antibiotics.

Treatment Risks

Risks may include, but are not limited to:

- Swelling, pain, and bleeding after treatment.
- Gum recession and root exposure.
- Sensitivity to hot, cold, and sweets.
- Infection.
- Increased spacing and food impaction between teeth.
- Initial looseness of teeth. Most will tighten up, but not all will.
- Numbness in the tissues.

Local Anesthesia Risks

I understand that I may receive a local anesthetic and/or other medication. In rare instances, patients may have a severe reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing or aspirating foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

No Warranty and Self Responsibility

There is no method currently available that will predict how the gum and bone will heal following any periodontal procedure. Because each patient's condition is unique, long-term success may not occur. In addition, the success of treatment can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, medications, and inadequate oral hygiene. I understand that after the proposed treatment has been completed, a constant monitoring of my condition will be necessary. This will mainly consist of regular 3-month recall visits to the office. I understand that my personal oral hygiene is the key to the prevention and successful treatment. If satisfactory plaque control is not maintained, recurrence of periodontal disease is likely.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE CONSENT AND AGREE TO START TREAMTENT AS PROPOSED BY THE DOCTOR.

Patient: _____ Date: _____

Doctor/Hygienist Performing Deep Cleaning: _____ Date: _____