dentalarts
DAVIS SQUARE

Informed Consent for Periodontal Pocket Reduction Therapy

Please read the following information carefully. Risks associated with your periodontal therapy are explained below. Please take the time you need to ask all your questions before you sign.

Periodontal therapy can be required for a variety of reasons. These reasons include the persistence of periodontal pockets that results in the inability to properly clean the teeth, the presence of infection and the loss of bone support to the teeth. Periodontal therapy is performed to reduce or eliminate these pockets, remove unhealthy tissue and to thoroughly clean the root surfaces of the teeth. However, due to many factors such as advanced state of disease, lack of adequate home care, nutritional or hormonal factors and personal habits, your problem may persist or even worsen with time. This can result in the loss of teeth.

Following periodontal therapy, the success of your periodontal therapy is largely dependent upon following your post-operative instructions and presenting for necessary follow-up care as outlined by your dentist. Immediately following periodontal therapy, you may experience increased sensitivity of the tooth roots to cold, heat or sweets. This typically decreases over time, but the intensity and duration of discomfort vary greatly from person to person. Please be assured that we will use the utmost care in performing this procedure to assure a successful outcome.

I have read the above and have discussed with the Dentist the risks and treatment options of periodontal therapy. I understand that while the procedure is not a guarantee of permanent gum pocket reduction, it is currently the best treatment available to restore pocket depth. I hereby give my permission to proceed with the periodontal therapy.

_____ _____

Date Signature of Patient

Please read and sign the following if you wish to decline the recommended treatment.

I have been warned of the consequences of refusing the periodontal therapy. I understand that this recommended treatment is needed. However, at this time, I cannot arrange for the needed treatment and release the Doctor and his/her staff completely of any responsibility for dental problems that may result from my refusal to proceed with treatment.

_____ _____

Date Signature of Patient