Dreamwork Dental Care

Periodontal Scaling Consent

I, the undersigned, have been informed that I have periodontal disease, and this disease process has been explained to me and I fully understand the following:

1. This disease has resulted in the loss the bone which normally supports the teeth. To prevent the further bone loss around my teeth, I must prevent buildup of bacterial plaque on a daily basis and it is my responsibility to schedule the regular dental checkups and cleansing after treatment is complete.

2. The proposed treatment plan to arrest the effects of periodontal disease that has been explained to me and I understand that additional treatment may be needed later if further problems develop.

3. As a result of periodontal root planing and curettage:

    a. The gums will be more receded where cleaned, and portions of the roots will be exposed post-cleaning. The exposed roots will be more sensitive to hot, color and/or sweets. This problem usually corrects itself in about six months time. Occasionally, further treatment may be needed. On rare occasions, this condition persists no matter what is done.

    b. The exposed roots, being more porous, will stain more easily than the crowns of teeth. The teeth may be more loose immediately after cleaning. This occasionally persists indefinitely on isolated teeth where more bone loss has taken place. Normally, the teeth will eventually be about as loose as they were pre-operatively.

    c. If significant bone loss has occurred around upper front teeth, speech may be slurred post-operatively. In more severe cases, an appliance may be needed to replace missing gum tissue around front teeth for esthetics and to correct this speech problem.

4. Failure to follow these recommended actions will most likely result in continued bone loss with probably periodontal abscesses and eventually, tooth loss.

5. After an appropriate healing period, the status of periodontal disease will be evaluated. At that time, referral to a periodontist for periodontal surgery may be indicated. I acknowledge that no guarantees have been made to me. The risks involved in the administration of anesthetics and the surgery itself have been fully explained to me and I give my voluntary informed consent to the same.

Patient Signature_____**Date**_____

Dr. _____**Witness** _____