Consent for Periodontal Scaling/ Root Planing

I hereby authorize Dr.Wiesenmayer or my dental hygienist to perform scaling and root planing on tooth (teeth) _____, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Alternative Treatments include
_____.

I understand that I have periodontal (gum and bone) disease. I understand that it is caused by bacterial toxins (poisons) and my host response to these toxins. I realize that though this disease may be painless and without symptoms, usually bleeding, swelling or recession of gum tissue, loosened teeth, elongated teeth, bad breath, or sensitivity exists. Therapy involves scaling and root planning but may require more extensive treatment. Periodontal scaling and root planing involves the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum (the outer covering of the root surface) and diseased tissue from the inner lining of the crevice surrounding the teeth. The purpose of this procedure is to reduce some of the causes of periodontal disease to a level more manageable by my individual immune system. **I understand that my own efforts with home care are just as important as my professional treatment.** I have been informed that the risks to my health if this procedure is not performed include, but are not limited to progression of the disease with increased bone loss and possible eventual tooth-loss, increased infection, systemic problems, bleeding, pain, and soreness.

Potential Risks and Complications:

1. Increased recession of gum tissue and exposure of root surfaces (as tissue heals, swelling decreases).
2. Increased sensitivity to hot, cold, or sweets. This may require further treatment, may fade with time, or may persist no matter what is done. Exposed roots may acquire stain more readily.
3. Food may collect between teeth. Proper cleaning techniques will be explained in detail.
4. If teeth were loose prior to the procedure, they may seem looser immediately after, usually after healing, teeth "tighten".
5. Some pain, swelling or bruising may be experienced after treatment.

I certify that I have read the above and fully understand this consent for treatment. I understand that a perfect result cannot be guaranteed. I am aware of the fee(s) associated with this treatment and am responsible for any and all payments not covered by my insurance.

Patient Signature _____ Date _____
Doctor Signature _____ Witness Signature _____