Sample Form: Discussion and Consent for Periodontal (Gum) Treatment

Patient's Name:_____ Date of Birth:_____
Last *First* *Initial*

I am being provided with this information and consent form so that I may better understand the treatment recommended for me. Before making a treatment decision, I wish to be provided with sufficient information, in a way I can understand, in order to make a well informed decision regarding my proposed treatment.

I understand that I may **ask any questions I wish,** and that it is better to ask questions prior to treatment than to wonder about it after treatment has started.

Nature of the Recommended 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 (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:

☐ Gingivitis (dental plaque (biofilm) related)
☐ Drug-related tissue enlargement ☐ Other local/systemic risk factors:_____
☐ Gingival disease (not plaque related—such as specific infections, developmental disorders, immune conditions, traumatic lesions):
_____

☐ Periodontitis

Severity and Complexity
☐ Stage I (Initial)
☐ Stage II (Moderate)
☐ Stage III (Severe with possible tooth loss)
☐ Stage IV (Severe, with possible loss of dentition)

Disease Extent
☐ Localized
☐ Generalized
☐ Molar/Incisor

Grade/Progression
☐ Grade A (slow progression)
☐ Grade B (moderate progression)
☐ Grade C (rapid progression)

☐ Peri-implant disease
☐ Peri-implant mucositis ☐ Peri-implantitis ☐ Hard/soft tissue implant site deficiencies:_____
☐ I have been informed that my condition requires regular and ongoing follow-up and maintenance visits to prevent progression of disease and further loss of supporting bone and gum tissue.
☐ Other (as specified):_____

Teeth or area that applies to each diagnosis:_____

_____

continued…

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 _____ visit(s) 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 options to treat my periodontal dental condition include _____

_____

☐ No other reasonable treatment option exists for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____.

Patient's Initials

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 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 topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact Dr. _____ if numbness remains more than a few hours or if you develop a rash. 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. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues. Other risks of my treatment include:

_____

continued…

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 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

☐ Other:_____

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about.

Patient's Initials

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including medications I am currently taking (antibiotics, pain drugs, or other medications, including non-prescription medicines, herbs or supplements) and materials or medicines to which I am allergic. I will follow any and all treatment and post-treatment instructions as directed and explained to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended [treatment unique to form] is necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment.

I, _____, have received information about the proposed periodontal treatment. I have discussed my treatment with Dr. _____ 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 and placement of dental implants). I understand the risks associated with this treatment and elect to have this procedure performed by Dr. _____. I understand that if any unexpected difficulties occur during treatment, I may be referred to a periodontist for further care.

Patient's Initials

Signed:_____ Date:_____

Patient or Guardian

Signed:_____ Date:_____

Treating Dentist

Signed:_____ Date:_____

Witness