Sample Form: Discussion and Refusal of Periodontal (Gum) Treatment

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

I am being provided with this information and refusal form so I may fully understand the treatment recommended for me and the consequences of my refusal. Before making a treatment decision, I wish to be provided with enough 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 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	**Disease Extent**	**Grade/Progression**
☐ Stage I (Initial)	☐ Localized	☐ Grade A (slow progression)
☐ Stage II (Moderate)	☐ Generalized	☐ Grade B (moderate progression)
☐ Stage III (Severe with possible tooth loss)	☐ Molar/Incisor	☐ Grade C (rapid progression)
☐ Stage IV (Severe, with possible loss of dentition)		

☐ 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:_____

_____

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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 $_____

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:

_____

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

continued…

Acknowledgment

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 associated with recommended treatment, and the risks of refusing treatment.

(The following release is optional.)

I personally assume the risks and consequences of my refusal, and release for myself, my heirs, executors, administrators, or personal representatives those dentists who have been consulted in my case from any and all liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

I do NOT wish to proceed with the recommended periodontal treatment.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist

Signed:_____ Date:_____
Witness