CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

I understand that I have periodontal (gum and/or bone) disease. The disease process has been explained to me and I understand that it is caused by bacterial toxins (poisons) and my host response to these toxins. I realize that this disease may be painless and without symptoms, but that usually symptoms such as bleeding, swelling, or recession of gum tissue, loosened teeth, elongated teeth, bad breath, or sensitivity and soreness may be noticed. Treatment of periodontal disease may include periodontal scaling and root planing, either as a therapeutic procedure or preliminary to 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.

Consequences of doing nothing about my periodontal condition may be, but are not limited to:

- **Increased recession of gum tissue and exposure of root surfaces**
- **Increased sensitivity to hot, cold, or sweets; this may require further treatment, may fade with time, or may persist despite treatment**
- **Increasing tooth mobility (loose teeth)**
- **Loss of teeth**
- **Food collection between teeth**
- **Continued infection of the gums and other supporting structures**
- **Spread of infection to other sites in the body**

_____I understand the recommended treatment, the risks of such treatment, and any alternative treatment and risks that have been explained to me. I understand the fee(s) involved in the treatment as well as consequences of doing nothing.

_____I give permission for the use of local anesthetic and any anxiolytic and/or sedative medications that may become necessary. The possible side effects of local anesthetics are prolonged or permanent numbness of the lips, cheeks, or gums, rapid heart rate, allergic reactions, and reactions with other drugs that I am taking.

Patient Signature: _____ Date: _____

Printed Name: _____ Provider Initials: _____