Informed Consent: Periodontal Scaling and Root Planing

Scaling and Root Planing: Periodontal disease involves the soft tissue surrounding the teeth (gum tissue). The causes of this disease are complex and may include genetic factors, hard and soft deposits on the teeth (plaque or calculus), and various bacteria and their toxins. Symptoms include bleeding gums, swelling, infection, bad breath, tooth and root sensitivity, gum recession, loosened teeth, and possible loss of teeth. Scaling and root planing treatment includes the removal of all debris and bacterial plaque, and monitoring of home care to maintain tissue health.

Treatment Risks: This treatment may result in unintended consequences, including, but not limited to, bleeding; infection; tissue swelling or bruising; increased sensitivity to hot, cold, or sweets; esthetic changes; exposure of crown margins; exposed root surfaces due to recession of gum line; pain in the associated teeth, including roots; temporary or permanent numbness; and tooth mobility or loss.

Recall (check one):
After scaling and root planing, I will be placed on a _____ three-month recall, _____four-month recall, or _____six-month recall to monitor my home care.

Drugs, Medications, and Sedation: Drugs, medications, or anesthesia/sedation can cause allergic and other reactions. Examples include, but are not limited to, swelling, redness, itching, vomiting, diarrhea, and numbness, or tingling of the lip, gum, or tongue (which in rare cases may be permanent), as well as, in rare cases, anaphylactic shock. Since drugs, medications, or anesthesia/sedation also may cause drowsiness and impair coordination or awareness, patients should not operate a motor vehicle or hazardous device before achieving full recovery. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days, as well as those that have been prescribed within the last six months but not taken, and of all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by my dentist may result in continued or aggravated infection and pain, and potential resistance to effective treatment. I also understand that antibiotics can reduce the effectiveness of birth control pills.

I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and have had all of my questions answered before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan.

_____	_____
Patient Name	Date
_____	_____
Patient Signature	Witness