NORTHBRIDGE SMILES

Periodontal Scaling and Root Planning

Patient Name _____ Procedure _____

I understand that I have periodontal (gum and bone) disease. The disease has been explained to me and I understand it is caused by bacterial toxins (poisons), and how my body has responded to these toxins. I realize that this disease may be painless and asymptomatic, 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 planning, either as a therapeutic procedure or preliminary to more extensive treatment. Periodontal scaling and root planning is the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum (the outer covering of the root). The purpose and benefit of this procedure is to reduce some of the causes of periodontal disease to a level more manageable by my own individual immune system. I understand:

1. My own efforts with home care are just as important as my professional treatment.
2. Some of the conditions caused by periodontal disease are irreversible.
3. The consequences of doing nothing about my periodontal condition may be, but are not limited to:
    a. Worsening of the disease with increase bone loss
    b. Possible eventual tooth loss
    c. Increased infection
    d. Systemic problems
    e. Bleeding
    f. Pain and soreness

    The treatment risks may be, but are not limited to:

    a. Increased sensitivity to hot, cold or sweets. This may require further treatment, may fade with time, or may persist no matter what is done.
    b. Exposed roots may acquire stain more readily
    c. Food may collect between teeth. Proper cleaning techniques will be explained in detail
    d. If teeth were loose prior to the procedure, they may seem looser immediately after. However, after healing, teeth usually "tighten"
    e. Some pain, swelling or bruising may be experienced after treatment

I understand the recommended treatment: the risks of such treatment and any alternative treatment and risks have been explained to me. I understand the fee(s) involved in the treatment as well as the consequences of not receiving treatment.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____

Informed Refusal for Periodontal Treatment

I, _____, the undersigned, understand the recommended treatment and hereby release Northbridge Smiles, its doctors, associates, hygienists, employees and agents from any injury I may incur or suffer as a result from my refusal to proceed with periodontal treatment or referral as recommended.

Patient's Signature _____ Date _____

Dentist's Signature _____ Date _____