SCALING AND ROOT PLANING INFORMATION AND CONSENT FORM

1. I have been informed of the possible risks and complications involved with scaling and root planing, prophylaxis, and anesthesia. Such complications include pain and root sensitivity. Numbness of the lip, tongue, chin, cheek or teeth may occur. The exact duration is variable and is rarely irreversible.

2. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness and movement of teeth, followed by necessity of extraction. Also, possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles and tired muscles when chewing.

3. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome or results of treatment can be made.

4. I understand that smoking, alcohol, or eating prohibited foods may effect gum healing and may limit the success of this or any procedure. I agree to follow my doctor's and hygienist's home care instructions and also comply with proper post scaling re-evaluation appointments with the doctor to assess the outcome and determine the need for further intervention.

5. I understand that this treatment will likely require a minimum of two visits with the practitioner prior to reevaluation.

6. I agree to the type of anesthesia, depending on the choice of the practitioner, following proper explanation. **If** given a sedative, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care. I understand that I must not drive to and from the scaling and root planing appointment if sedation is given.

7. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, cardiac/blood pressure issues, gum or skin reactions, abnormal bleeding or any other conditions related to my health. I have listed all medications taken including over the counter medications, vitamins and herbals. I will keep my doctor updated on any changes to my health.

8. I request and authorize these dental services for me. I fully understand that during, and following the contemplated procedure or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

Patient Name ______________________________

Knowledge of Consent for Scaling and Root Planing

______ a. I am aware and accept that, in addition to the risks described on the previous page (as the practice of dentistry is not an exact science), there may be other risks not usually encountered or expected that may occur. I also acknowledge that no guarantees have been made to me about the results of the proposed treatment.

______ b. I authorize the administration of local anesthetics, nitrous oxide in combination with oxygen, sedatives, hypnotics and/or analgesics as indicated, to aid and assist in completing the treatment of procedures described in above.

______ c. I understand that photographs may be taken of me or my child, for educational or treatment related purposes. All photographs used for presentation or educational purposes are anonymous.

______ d. I have had an opportunity to discuss my child's dental problem(s) and the proposed treatment plan(s) with the treating dentist and all questions have been answered to my satisfaction. Therefore, I believe I have adequate knowledge upon which to grant an informed consent to the proposed treatment.

______ e. I agree to report to my doctor for regular examinations as instructed.

______ f. I impose no specific limitations, constraints or prohibitions regarding treatment other than:

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Patient Signature______________________________________ Date________________

Surgeon Signature______________________________________ Date________________

Witness Signature______________________________________ Date ________________

If you are consenting to the care of another: I have the legal authority to sign this on behalf of:

Patient Name____________________________ Your relationship to patient________________

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Signature of legal guardian Date Witness signature

Patient Signature______________________________________ Date________________

Surgeon Signature______________________________________ Date________________

Witness Signature______________________________________ Date ________________

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