Smiles Of Carpentersville
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Informed consent for Scaling and Root Planing

_____ _____
Patient's Name (PLEASE PRINT) *Date*

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ 1. TREATMENT:
I understand that I have the following condition: periodontal disease.

_____ 2. DRUGS AND MEDICATIONS:
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions which, although rare, can lead to death. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. RISKS OF DENTAL ANESTHESIA:
I understand that pain, bruising and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with local anesthetics. About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

_____ 4. PERIODONTAL DISEASE:
Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, placement of locally administered antibiotic treatment, gum surgery and bone grafting, extraction of teeth and tooth replacement, as applicable. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall and perio maintenance appointments. I understand that care by a specialist may be necessary. I understand my teeth may be more sensitive to temperature changes due to the removal of calculus present on the roots but that has to be removed to prevent disease progression.

_____ 5. CHANGES IN TREATMENT PLAN:
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

ATTENTION:

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS: (Please circle if yes)
Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa, Bisphosphonate classes of medication

I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____ _____
Patient's or Guardian's Signature Date