ASSOCIATES IN PERIODONTICS, P.L.C.
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Holly A. Halliday, D.D.S. Matthew R. Kolesar, D.M.D., M.M.Sc.

CONSENT TO PERIODONTAL (GUM) TREATMENT

I hereby authorize Doctors Paul A. Levi, Jr., Brian D. Shuman , Holly A. Halliday and /or Matthew R. Kolesar and whomever they designate as their assistant(s), to perform the following treatment upon

_____
(patient name)

DIAGNOSIS
I have been informed that I have Periodontal (gum) Disease and/or deformities that could lead to the loss of certain teeth. I have been advised that the proposed therapy is intended to extend the life expectancy of my teeth. This consent form outlines that treatment program, it's expected consequences and limitations

TREATMENT PROCEDURES
_____ Oral Hygiene Instructions
_____ Polishing and scaling
_____ The administration of anesthetic agents topically and by injection
_____ Root planing and curettage
_____ Localized Antibiotic therapy
_____ Chemical pocket irrigation
_____ Biopsy of tissues for microscopic evaluation
_____ Occlusal/Bite adjustment
_____ Temporary tooth splinting
_____ Bite guard/snoring appliance/clenching grinding guard
_____ Extraction of teeth or root as determined during surgery
_____ Root desensitization therapy
_____ Periodontal Maintenance therapy
_____ Surgical Periodontal Treatment: _____

ALTERNATIVES
Further, I have been informed that possible alternatives to the above treatment include:
Maintenance therapy only
Root planing and maintenance therapy only
Extractions

We have discussed, however, that the procedures first recommended should be performed due to the improved prognosis.

NON-TREATMENT RISK
I further understand that if no treatment is rendered the risk to my dental health includes, but is not limited to, the following:
Premature loss of teeth
Gum Recession
Halitosis (bad breath)
Loosening of teeth
Abscesses (gum boils)
Tooth drifting, flaring or other tooth movement
Further deepening of periodontal and/or pus pocket
Further loss of bone

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TREATMENT RISKS

Risks of the treatment include, but are not limited to:

- Allergic or other reactions to medications and local anesthesia
- Swelling/Discomfort
- Thermal (hot/cold/sweets) sensitivity
- Exposure of margins of crowns (caps) and/or root surfaces
- Phonetic (speech) interference
- Infection
- Tooth mobility
- Food impacting between teeth
- Temporary restricted mouth opening
- Numbness of jaw or gum nerves
- Delayed or Inadequate Healing
- Gum Shrinkage
- Spaces between teeth
- Esthetic changes
- Tooth loss despite therapy
- Other_____

NO WARRANTY

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth. However, it is the Doctor's opinion that therapy will be helpful, and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.

It has been explained to me that the long term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment at a dental office. I have been fully informed of the nature of periodontal treatment, the procedure to be utilized, the risks and benefits of periodontal treatment, the alternative treatments available, and the necessity for follow-up and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist.

INFORMED CONSENT

After thorough deliberation, I hereby consent to the performance of periodontal treatment as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____ _____

PLEASE PRINT/SIGN: Patient name, parent or guardian Date

INFORMED REFUSAL

I am aware of the periodontal disease (gum disease) and infection present in my mouth. The recommended treatment plan, alternative treatments and the risks and benefits involved have been fully explained to me and I have had all of my questions answered. I completely understand the consequences of partial or non-treatment and am willing to assume all risks involved.

_____ _____

PLEASE PRINT/SIGN: Patient name, parent or guardian Date

_____ _____

PLEASE PRINT: Witness Date