CONSENT TO PERIODONTAL (GUM) TREATMENT

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I hereby authorize Cynthia A. Layport, DMD (hereinafter called "Doctor") to perform periodontal treatment upon

_____ (patient).

Diagnosis: I have been informed that I have periodontal (gum) disease and/or periodontal defects that could lead to the loss of certain teeth. I have been told that the purpose of the operation(s) is to improve the health of my gum tissue, teeth, and supporting bone. I accept this form as an outline of the recommended treatment, its objectives and limitations, and its ordinary after-effects.

Treatment Plan:

___ Scaling and root planing
___ Flap procedure with or without bone recontouring and bone grafting
___ Gingivectomy
___ Laser assisted new attachment procedure
___ Gum grafting
___ Extraction of teeth
___ Occlusal (bite) adjustment

Occlusal adjustment is essential to complete healing. It has been explained to me that some tooth structure and/or porcelain or metal of restorations will be removed.

Alternatives: Further, I have been informed that possible alternatives and/or supplemental methods of treatment include, but are not limited to:

___ Extraction(s)
___ Maintenance care (cleaning)
___ Root planing

Non-Treatment Risks: I further understand that if no treatment is rendered, the risks to my dental health include, but are not limited to:

___ Deepening of periodontal pockets
___ Loss of supporting bone
___ Gum recession
___ Loosening of teeth
___ Flaring, drifting or other tooth movement
___ Halitosis (bad breath)
___ Abscess (infection)
___ Loss of teeth

There may also be potential medical risks of untreated gum disease including heart disease and stroke.

Treatment Risks: After-effects of the operation(s) include, but are not limited to:

- Pain
- Swelling
- Gum recession
- Tooth mobility
- Thermal sensitivity (hot & cold)
- Irritation of lip tissue
- Root canal therapy
- Infection (including dry socket)
- Phonetic interference (speech)
- Unaesthetic exposure of crown (cap) margins
- Food impaction between teeth
- Restricted mouth opening
- Numbness of jaw or gum nerves
- Chronic pain or tingling

These conditions may last for several weeks, months or indefinitely.

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Pre-Operative Medication: I have been advised that sedative drugs may be administered. If taken, I agree that I will not drive myself home after surgery, but will arrange to be driven and accompanied home.

Medication: Local anesthetic agents, analgesic agents, and antibiotics may be used. Allergic reactions, and GI disturbance such as nausea or diarrhea may occur. Bone and/or tissue grafts may be used. These materials have been thoroughly treated and tested using the best of current techniques.

Unforeseen Conditions During Surgery: If any unforeseen condition should arise in the course of the operation(s) calling for the Doctor's judgment, or for procedures in addition to or different from those now contemplated, I request and authorize the Doctor to do whatever she may deem necessary.

Limitations of Treatment: Although it is the Doctor's opinion that treatment results will be satisfactory, no guarantee or assurance has been given that the proposed therapy will be curative and/or successful to my complete satisfaction. I realize that because of individual patient differences, the risks of failure, relapse, or worsening of my present periodontal condition can occur despite the best of care, and may require re-treatment and/or extraction of teeth.

Success can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and certain medications, including certain illegal drugs.

Maintenance is a Must: It has been explained to me that the success of treatment is significantly dependent upon my long-term and effective daily removal of bacterial deposits (plaque and calculus) from my teeth, as well as my adherence to a program of regular periodontal maintenance care at my dental office after the proposed active treatment is completed.

Periodontal disease patients require more frequent maintenance recalls than healthy patients, regardless of insurance limitations.

Photographs: I _____ do _____ do not consent to photographs and their publication for educational and scientific purposes. Images may also be used for marketing purposes, including the Doctor's website or the Internet. My identity will not be revealed.

Consent: I have been fully informed of the nature of treatment, the procedure to be utilized, the risks and benefits of such treatment, the alternative treatments available, and the necessity for follow-up and self care. I have had the opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with the Doctor. After thorough deliberation, I hereby consent to the performance of treatment.

I also consent to the performance of such additional or alternative procedures as may be necessary in the best judgment of Dr. Layport.

I further understand that my insurance reimbursement is only an estimate. I am ultimately responsible for any fees incurred during treatment. I understand this office does not operate on the assumption that insurance will reimburse me for the treatment rendered. I understand that this office is performing this treatment in my own best interests.

Patient (or Legal Guardian) Signature	Date	Doctor Signature