Dental Specialties of West Chester

Dr Barry Simms, M.S D.M.D

CONSENT TO PERIODONTAL (GUM) TREATMENT

I hereby authorize Dr. Barry Simms, (herein after called "Doctor") or their designated licensed dental professional(s), to perform the following treatment and/or surgery upon

____ .
(Name of Patient)

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, gum or skin reactions, abnormal bleeding or any other condition related to my health.

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 lists various treatments and their expected consequences and limitations. My treatment plan may include one or more of these procedures as discussed with me.

TREATMENT PROCEDURES

- Oral hygiene/disease prevention
- Microscopic assessment of subgingival scrapings
- Chemical pocket irrigation
- Removal and Biopsy of tissues for microscopic evaluation
- Polishing and scaling
- Root planning and/or curettage (tooth and/or gum scraping)
- Occlusal bite adjustment
- Temporary splinting
- Bite/Night guard
- Periodontal surgery (gingivoplasty; flap surgery with/without osseous contouring; osseous/alloplastic grafts; soft tissue grafts; gingivectomy; frenectomy; fiberotomy; crown lengthening; ridge augmentation; sinus lift; tori removal)
- Extraction of teeth or roots as diagnosed and/or determined during surgery
- Root desensitization therapy
- Nitrous oxide, oral sedation
- Preventive maintenance therapy (professional maintenance re-care)
- Implant dentistry

ALTERNATIVES

Further, *I have been informed* that possible alternatives to the above treatment include:

- Maintenance therapy only
- Root planning/curettage and maintenance therapy only
- Pre-surgical and maintenance therapy only
- Extraction(s)
- Other: ____

I understand that choosing these alternative treatments could put me at risk of losing teeth, but elect to do so at the present time.

NON-TREATMENT RISKS

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

- Premature loss of teeth and/or Loosening of teeth
- Gum recession
- Further deepening of periodontal and/or pus pockets
- Tooth drifting, flaring or other tooth movement
- Abscesses (gum boils)
- Halitosis (bad breath)
- Worsening of systemic health conditions including but not limited to cardiovascular disease, stroke, diabetes, and low birth weight babies

TREATMENT RISKS

I understand that the risks of the treatment include, but are not limited to:

- Swelling and/or facial discoloration
- Pain and/or sensitivity to hot and/or cold
- Tooth mobility
- Exposure of margins of crowns (caps) and/or root surfaces
- Food impaction and spaces between teeth
- Infection and/or delayed healing
- Temporary restricted mouth opening / muscle spasms
- Phonetic interferences (difficulty with speech)
- Root resorption
- Jaw joint injuries
- Bone fracture
- Perforation of the upper jaw sinus or nasal cavity
- Temporary or permanent numbness of lip, tongue, teeth, chin and gum nerves
- Other ____

CONSENT TO UNFORESEEN CONDITIONS DURING SURGERY

If any unforeseen condition should arise in the course of the operation, calling for the Doctor's judgment for procedures in addition to or different from those now contemplated, *I further request and authorize* the Doctor to do whatever he/she may deem advisable.

PRE AND POST OPERATIVE INSTRUCTIONS

Certain prescribed anti-anxiety medication may cause drowsiness, alone or in combination with alcohol or other sedatives. *I (the patient/guardian) have been advised* not to drive or operate dangerous machinery within 24 hours of taking such medication. Accordingly, *I (patient/guardian) have arranged* to be driven and accompanied home by another person.

SUPPLEMENTAL RECORDS AND OBSERVERS

In furtherance of the progression of dentistry and the dental health of the public, *I do hereby consent* to photography, filming, recording and x-rays being taken of my oral and facial structures, and subsequent publication solely for educational and scientific purposes, and to having health professional observers in the operatory for education purposes. Any images will be taken in such a way as to protect my anonymity.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS

I understand that smoking and/or alcohol intake may affect healing and may limit the successful outcome of my treatment. I agree to follow instructions related to the daily care of my mouth and post-operative instructions. I agree to report for appointments following my treatment as suggested so that my healing may be monitored and the Doctor can evaluate and report on the outcome of the treatment upon completion of healing.

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 further loss of supporting tissue or bone may 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 CERTIFY I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THIS DOCUMENT AND THE EXPLANATIONS REFERRED TO OR IMPLIED, AND THAT AFTER THOROUGH DELIBERATION, I GIVE MY CONSENT FOR THE PERFORMANCE OF ANY AND ALL PROCEDURES RELATED TO THE PERIODONTAL TREATMENT AS PRESENTED TO ME DURING THE CONSULTATION AND TREATMENT PLAN PRESENTATION BY THE DOCTOR OR AS DESCRIBED IN THIS DOCUMENT.

***** SIGN ONLY IN THE PRESENCE OF WITNESS FROM DR. BARRY SIMMS' STAFF*****

Patient Name ____

(Please Print)

____

Signature of Doctor

Signature ____

(If the patient is unable to sign or is a minor, signature of parent or legal guardian)

____

Signature of Witness

____

Relationship to Patient

____

Date