MedPro Group
a Berkshire Hathaway company

Patient Name: _____

Date of Birth: _____

Informed Consent for Periodontal Treatment

I. Recommended Treatment

I hereby give consent to Dr. _____ to perform Periodontal Treatment procedure(s) on me or my dependent as follows: _____ _____ ("Recommended Treatment") and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: _____ _____ but I wish to proceed with the Recommended Treatment described above.

III. Risks and Complications

I understand that there are risks and complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These potential risks and complications, include, but are not limited to, the following:

1. Tooth sensitivity.
2. Pain from treatment.
3. Infection.
4. Swelling.
5. Dark spaces between teeth where there is no longer any gum tissue.
6. Changes in how long my teeth appear (due to re-contouring).

7. Gum tissues may shrink or recede. This change may make some previous dental restorations (i.e., crowns, fillings) more noticeable and the restorations may need to be replaced for cosmetic purposes.

8. Loss of bone or tissue graft.

9. Possible involvement of the nerves of the lower jaw resulting in temporary or permanent tingling of the lower lip, chin, tongue or surrounding structures.

10. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.

11. Future bone or tooth loss.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

Witness (signature): _____