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**Discussion and informed consent for Medicated Cleaning**

Patient name: _____ Date:_____

Refer treatment plan.

**Facts for consideration**

**Patient's initials required**

___An examination of your oral cavity includes measuring the pockets under the gums surrounding your teeth to determine which periodontal treatment(s) your gum condition requires. Dental x-rays will be taken to check the condition of the bone that supports your teeth.

___ Periodontal (gum) treatment is intended to remove the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus, which is an accumulation of hard deposits on the tooth above or below the gingival margin.

___ The treatment involves scaling, which uses sharp hand instruments to remove calculus, plaque and bacteria' curettage involves scraping and removing any necrotic (dead) tissue, cleans the area or pocket and root planning smooth's and contours the root surfaces to remove the debris and cementum found in the periodontal pocket. Medications or a special mouth rinse can be used to help control the growth of bacteria, may also be part of treatment

___The success of the treatment depends in part on your efforts to properly brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow proper home care taught to you by this office.

___A topical or local anesthetic may be administered just before treatment depending on the sensitivity of the area to be treated.

**Benefits of Medicated Cleaning Treatment, Not Limited To The Following:**

___ Regular, professional dental cleaning create a clean environment in which your gum can heal; reduce the chances of further irritation and infection; make it easier for you to keep your teeth clean; and decrease the cost of replacing teeth lost due to gum disease.

**Risks of Medicated Cleaning Treatment, Not Limited To The Following:**

Initial: _____

___I understand that one of the effects of treatment is that my gums may bleed or swell and I may experiences discomfort for several hours after the anesthesia wears off. There may be soreness for a few days, which may be treated with pain medication. I will notify the office if condition persists beyond a few days.

___I understand that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which may require treatment with antibiotics.

___I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the even this occurs, I must notify this office if I experiences persistent trismus or other similar concerns arise.

___I understand that after treatment, as my gum tissue heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that additional surgical procedures are available to treat the exposed areas.

___I understand that depending on my current dental condition, existing medical problems, or medications I may be taking, these periodontal treatment methods alone may not completely reverse the effects of gum disease or prevent further problem.

___I understand that I may receive a topical or local anesthetic and/or other medication as part of my treatment. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention. **Because of the anesthesia, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury causing numbness or pain of the lip, chin, teeth or tongue, may result from an injection.

___I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore it is critical that I tell my dentist of all medications and supplements I am currently taking, which are _____

___I understand that smoking can adversely affect the outcome of the medicated cleaning suggested and that final results achieved by the medicated cleaning can be lessened or can cause the outright failure of the treatment by the fact that I have had a recent history or smoking.

___I understand that every reasonable effort will be made to ensure that my condition is treated properly, although it is not possible to guarantee results. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand, and that all of my questions have been answered to my satisfaction.

**Consequences If No Treatment Is Administered, Not Limited to the Following:**

Initial: _____

___ I understand that if no treatments were administered or ongoing treatment was interrupted or discontinued, my periodontal, condition may continue and probably worsen. This could lead to further inflammation and infection of gum tissues, tooth decay above and below the gumline, deterioration of bone surrounding the teeth and eventually, the loss of teeth.

**Alternatives To Medicated Cleanings Treatment, Not limited to the Following:**

__ I understand surgical methods may also be prescribed to help control my gum disease. I have discussed with my dentist the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits and costs.

**Alternative discussed**: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

**Check only one of the boxes below that applies to you:**

- o I have been given the opportunity to ask questions and **give my consent** for the proposed treatment as described above.

**OR**

- o I **refuse to give my consent** for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

Patient's or Patient's Representative Signature Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to non-surgical periodontal treatment with _____ (patients name) who has had the opportunity to ask questions, and I believe my patient understand what has been explained and willingly consents to treatment.

Dentist's signature: Date

Witness Signature Date

Initial: _____