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Informed Consent for Periodontal Scaling and Root Planing (Deep Cleaning)

It has been recommended by your dentist and hygienist that you receive a deep cleaning in all or parts of your mouth in order to manage active periodontal (gum) disease with the use of anesthetic and possible antibiotic placement. If left untreated, periodontal disease can cause tooth loss and other adverse consequences to your general health. The purpose of this therapy is to reduce some of the causes of periodontal disease and promote healing. Additional treatment may be necessary to control gum disease and prevent tooth loss (ie- referral to a gum specialist (periodontist), gum surgery, tooth extraction, etc).

As with all procedures, there are risks associated with scaling and root planing. These risks include, but are not limited to the following:

1. Swelling, pain, and bleeding after treatment
2. Gum recession, root exposure, and/or sensitivity
3. Infection
4. Increased spacing and food impaction between teeth
5. Increased tooth mobility
6. Numbness in tissues
7. Broken instruments during cleaning which may require surgical retrival

Outcomes and Patient Responsibility
Because of variables within each patient's physiological makeup, it is impossible to predict exactly how the gums and supporting structures will respond to any periodontal procedure. Therefore, additional treatment may be necessary.
It is mandatory that the patient exercise extreme diligence in performing homecare and maintaining the recommended recall as there is no cure for periodontal disease. It must be maintained at home and with regular recare appointments. Without this, the probability of unsatisfactory results and reoccurrence is greatly increased.

Consent
I have been given the opportunity to ask questions regarding the nature and purpose of my periodontal treatment and have received satisfactory answers. I voluntarily assume any risks that may be associated with any phase of this treatment in the hopes of obtaining the desired results. No promises have been made to me concerning my recovery and/or results of this treatment. The fees for these services have been explained to me and are acceptable. By signing this form, I am freely giving my consent to allow Dr. Larry Herwig and his staff to render any treatment necessary or advisable for my dental conditions, including all anesthetics and/or medications.

Patient Signature ______________________________________ Date______________

Printed Name____

Witness Signature______________________________________