PREMIERE DENTAL

Periodontal Scaling and Root Planing Informed Refusal

Patient Name _____

I understand that I have periodontal (gum and bone) disease. The disease process has been explained to me and I understand it is caused by bacterial toxins (poisons), and how my body has responded to these toxins. I realize that this disease may be painless and asymptomatic, but that usually symptoms such as bleeding, swelling or recession of gum tissue, loosened teeth, elongated teeth, bad breath, or sensitivity and soreness may be noticed. Treatment of the periodontal disease may include periodontal scaling and root planing, either as a therapeutic procedure or preliminary to more extensive treatment. Periodontal scaling and root planing is the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum (the outer covering of the root surface), and diseased tissue from the inner lining of the crevice surrounding the teeth.

This treatment recommendation is based on visual examination, periodontal probing and charting, x-rays, other diagnostic tests, any models or photos taken, and on my doctor's knowledge of my medical and dental history. The treatment is necessary because of periodontal (gum) disease that has been diagnosed as:

☐ Chronic generalized periodontitis ☐ Chronic localized periodontitis

☐ Aggressive generalized periodontitis ☐ Aggressive localized periodontitis

Risks of Not Having the Recommended Periodontal Treatment

I understand that complications to my teeth, mouth, and/or general health may occur if I do NOT proceed with the recommended treatment. These complications include: Pain, Bleeding, Swelling, Mouth odor, Tooth mobility, Tooth loss, Additional infection, Complication of other health issues (such as diabetes, heart disease, stroke), Inability to proceed with other dental care.

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about.

PREMIERE DENTAL

Informed Refusal for Periodontal Treatment

I, _____, have received information about the proposed periodontal treatment. I have discussed my treatment with Dr. _____ and his team and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and my refusal of care.

I personally assume the risks and consequences of my refusal, and release for myself, my heirs, executors, administrators, or personal representatives those dentists who have been consulted in my case from any and all liability for ill effects that may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.
I do NOT wish to proceed with the recommended periodontal treatment.

Patient/Guardian Name: _____ Signature:_____ Date: _____

Doctor Name: _____ Signature: _____ Date: _____