INFORMATION ABOUT PERIODONTAL TREATMENT

Patient: ____

Periodontal treatment is performed in an attempt to retain teeth which otherwise might require extraction. A high degree of success is achieved provided that the patient follows through with treatment, has excellent home care, and stays on a frequent cleaning schedule as determined by the doctor. Periodontal surgery is often required to accomplish the desired results.

During your course of treatment, every effort will be made to achieve a successful result and keep you as comfortable as possible.

TREATMENT RISKS: There are potential risks in any medical treatment. The post-operative risks for periodontal treatment are usually temporary and include, but are not limited to, the following:

Swelling
Pain
Thermal sensitivity
Numbness of the jaw, lip, tongue, chin, or gum
Tooth mobility
Food impaction between teeth
Phonetic interference
Temporary restricted mouth opening
Exposure of margins of crowns or caps
Gum recession
Infection

ALTERNATIVES: Alternative treatment plans and or procedures include:

Extraction of infected teeth, pre-surgical therapy only or maintenance therapy only. However, complete periodontal treatment offers the best option to preserve teeth for the longest period of time.

NON-TREATMENT RISKS: The risks to my health include, but are not limited to the following:

Premature loss of teeth
Gum recession
Halitosis (Bad breath)
Loosening of teeth
Abscesses (gum boils)
Tooth drifting, flaring or other tooth movement
Further deepening of periodontal and / or pus pockets
Possible increased risk of stroke and cardiovascular disease
Possible difficulty regulating diabetic medications

EXTRACTION OF TOOTH RISKS:

Drifting or tipping of adjacent teeth leading to problems in chewing, and pain or tenderness from the jaw joint
Loss of support for the cheeks leading to wrinkles and caving in of the face
Need for replacement of the extracted tooth or teeth
Numbness of the jaw, lip, tongue, chin, or gum
Pain and swelling
Loss of jaw support

DELAY IN TREATMENT MAY ULTIMATELY REQUIRE THE LOSS OF A TOOTH THAT COULD OTHERWISE BE RETAINED.

I acknowledge reading the above and understand its contents, and have been given the opportunity to ask any questions regarding periodontal treatment.

Patient's signature: ____________________________________ Date: ______________
(Parent or Guardian if a minor)

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