Menlo Park Dental Excellence-ChauLong T Nguyen Dental Corporation
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Discussion and Informed Consent for LASER Periodontal Treatment

Patient Name: _____**Date**:_____
Diagnosis: _____
Treatment: _____

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 planing* smooths 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, and may also be part of the treatment.

_____ We use LASER optic fiber to reach the base of sulcus to eliminate and remove bacteria.

_____ The success of the treatment depends in part on your efforts to 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 LASER Periodontal Treatment, Not limited to the following:

_____ Regular, professional dental cleanings create a clean environment in which your gums 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 LASER Periodontal Treatment, Not limited to the following:

_____ I understand that one of the effects of treatment is that my gums may bleed or swell and I may experience moderate 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 conditions persist beyond a few days.

_____ 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 event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____ I understand that after treatment, as my gum tissues 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 problems.

_____ 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, cheek, 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 periodontal therapy suggested and that final results achieved by periodontal therapy can be lessened or can cause the outright failure of the treatment by the fact that I have had a recent history of 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 this information, and that all of my questions have been answered to my satisfaction.

Consequence if No Treatment is Administered, Not Limited to the Following:

_____ I understand that if no treatment was 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 the gum tissues, tooth decay above and below the gumline, deterioration of bone surrounding the teeth and eventually the loss of teeth.

Alternatives to LASER Periodontal Treatment, Not Limited to the Following:

_____ I understand that 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.

Alternatives 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:

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

OR

- ❑ **NO**, 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's Signature Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to LASER periodontal treatment with the patient who has had the opportunity to ask questions, and I believe my patient understands what has been explained and willingly consents to the treatment.

_____ _____

Dentist's Signature Date

_____ _____

Witness (Staff) Signature Date