

CONSENT TO PERFORM PERIODONTAL SCALING AND ROOT PLANING

I understand that periodontal procedures include risks and possible unsuccessful results from such treatment. Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions through scaling and root planing and related procedures, there are no promises or guarantees as to the anticipated results. I agree to assume those risks and possible unsuccessful results associated with but not limited to the following:

1. Response to treatment: Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by Dr. Bohra and myself. Should the desired results not be attained, surgery or extractions may be required.
2. Postoperative patient responsibility for care: With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment as instructed by Dr. Bohra and his hygienists.
3. Pain, soreness and sensitivity: There may be postoperative discomfort which may be transitory or permanent. Hot, cold, stimuli, contact with teeth and sweet or sour foods may cause some discomfort. This problem usually corrects itself.
4. Recession of gum tissues: After healing occurs, there may be gum recession which exposed the margins or edges of crowns or fillings, increasing sensitivity of teeth and creating esthetic or cosmetic changes. This may result in longer teeth and wider interproximal spaces, visible as black triangles. These wider spaces are more likely to trap food. The exposed root surfaces being more porous may stain more easily.

Failing to follow these recommended actions will most likely result in continued bone loss with probable periodontal abscesses and eventually tooth loss. It has been explained to me that following periodontal treatment I will need to continue with periodontal maintenance alternating every 3- 4 months between Dr. Bohra's office and my general dental office.

Informed consent: I have been given the opportunity to ask questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promise or guarantees have been made to me concerning my recovery and results of treatment. The fee (s) for this service has been explained to me and is satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Bohra, West Valley Periodontics and his hygienists to render any treatment necessary or advisable to my dental conditions including any and all anesthetics and/or medications.

Signature of patient

date

Witness to signature

date