Chase M.
BAKER, DDS

Informed Consent for Soft Tissue Management

PATIENT NAME_____ DATE_____

TO THE PATIENT

You have been diagnosed with a condition known as Periodontal Disease or Gum Disease. You have the right, as a patient, to be informed about your condition and the recommended treatment procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. Please ask about anything that you do not understand.

ABOUT THE TREATMENT

Periodontal Disease is a chronic incurable disease cause by the toxins and enzymes release by the bacteria in plaque and tarter and the body's inflammatory response to the toxins and enzymes. All treatment is performed in order to decrease the inflammation and create a healthy environment in the gums. Then, you can maintain that environment so that the inflammation does not return. The key to successful periodontal treatment is your ability and commitment to keeping the teeth clean and the gums free of inflammation after the therapy.

- Type I – Gingivitis- This is the early stages of the disease where the inflammation only involves the gum tissue and hasn't progressed to the bone. Normally there is a two (2) appointment treatment program. The first appointment is used to go over home care techniques and to perform a debridement that removes any tartar, build up plaque, and toxins in the gums. This allows the tissue to begin to heal. At the second appointment, the hygienist will measure the gum depths, and clean and polish teeth. Your re-care maintenance interval will be set at that time based on your gums' response to the debridement.

- Type II- Early Periodontitis- This is the early stage of the disease after it has progressed to the bone and there has been some bone loss and early formation of pockets. At this stage a more thorough treatment regime is required. In order to remove the toxins, enzymes, and tartar from the pockets two (2) appointments of Scaling and smoothing of the roots with anesthetic is required. We numb the gums and then get down into the groove around the neck of the tooth and remove the bacterial toxins and tartar. At the last appointment we check the healing and polish the teeth.

- Type III and IV- Moderate to Advanced Periodontitis- This is the moderate to more advanced version of the disease with more advanced bone destruction. The same treatment is required for this stage as above but may require up to four (4) appointments of the Scaling and Smoothing. After this treatment and depending on your tissue's response, surgery may be required to remove excess tissues caused by the loss of bone.

- Arestin Topical Antibiotic- A new form of antibiotic has been recently developed which specifically treats the bacteria that are present in the pockets. It is usually applied at the time of the Scaling and Root Planing and twice more at 3 month intervals as needed. This treatment has been shown to reduce the pocket depths in pockets which measure 5mm or more. This treatment may reduce or remove the need for surgical treatment and be an aid to keeping the bone destruction from progressing further.

BENEFITS AND ALTERNATIVES

Periodontal disease treatment can help to create a clean environment in which you gums can heal. It can also reduce the chances of further gum irritation or infection by making it easier for you to keep your teeth clean. Given your condition, there are no effective alternative treatments for treating gum disease and keeping the effected teeth. The success of these treatment procedures are dependant on your commitment to brush, floss, and return for proper post operative cleaning appointments. Other factors are the lack of smoking and good general health with a proper diet. Depending on the seriousness of your current condition, existing medical problems or medications you may be taking, these methods may not completely reverse the effects of gum disease or prevent future problems. Teeth that become loose as a result of periodontal disease may be extracted, which might require replacing the tooth or teeth with a fixed bridge, a removable partial or a full denture or implant with crown.

COMMON RISKS

The Doctor has explained to that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance such operative risks include, but are not limited to:

I. **Post operative discomfort and swelling, which may necessitate several days of home recuperation.**
II. **Bleeding that may be prolonged.**
III. **Post-operative infection requiring additional treatment.**
IV. **Stretching of the corners of the mouth with resultant cracking and bruising.**
V. **Restricted mouth opening for several days or weeks.**
VI. **Increased hot and cold sensitivity from exposure of the roots from shrinkage or surgical reshaping.**
VII. **Exposed edges of crowns and the appearance of longer teeth from the removal of some of the gum tissue.**
VIII. **In rare instances, some patients may have an allergic reaction to the local anesthetic which may require emergency medical attention. Some patients feel it is hard to swallow after the anesthetic is given since the back part of their mouth may be numb.**

PLEASE INITIAL EACH OF THE FOLLOWING:

X_____ I consent to the administration to such local anesthesia as deemed necessary by the above named Doctor to accomplish the proposed procedure.

X_____I have had an opportunity to discuss with the Doctor my past medical and health history including any serious problems and injuries.

X_____ Due to individual patient differences there exists a risk of failure, relapse, need for selective retreatment, or worsening of my present condition despite the care provided. However, it is the Doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I CERTIFY THAT I HAVE AN OPPORTUNITY TO READ FULLY ANDUNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE PROCEDURE AND THE EXPLANATION REFERRED TO OR MADE, ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WRE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ASLO STATE THAT I READ AND WRITE ENGLISH.

- o I GIVE CONSENT FOR THE TREATMENT AS DESCRIBED ABOVE.
- o I REFUSE TO GIVE MY CONSENT FOR THE PROPOSED TREATMENT AS DESCRIBED ABOVE; I HAVE BEEN EXPLAINED AND UNDERSTAND THE POTENTIAL CONSEQUENCES OF MY CHOICE.

X_____ X_____

PATIENT, PARENT, GUARDIAN DOCTOR

X_____ X_____

HYGIENIST DATE