Purdy's Wharf Dental Group

CONSENT FORM FOR PERIODONTAL TREATMENT

Patient Name: _____

1. I consent to and authorize Dr. Greg Thistle and such hygienists/assistants as may be selected by him to provide periodontal treatment to remedy the conditions or symptoms which appear indicated by the diagnostic studies and/or evaluations already performed.

2. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of treatment. I am aware that there is a risk that treatment may fail or have limited success. Further corrective treatment may be required and/or tooth loss may occur.

3. I am aware that in the case of a surgical procedure, there are possible complications. These include, but are not limited to: limited oral function, postoperative pain, bleeding, infection or abscess, bruising, allergic reaction to medications, a change in sensation such as numbness of the lip, chin, gums, or tongue, which may be of a temporary or permanent nature, injury to the maxillary sinus, temporomandibular joint (jaw joint) problems, and poor or delayed healing.

4. I understand that if nothing is done to correct my dental condition, any of the following may occur: limited function, gum or bone disease, loss of supporting bone, inflammation, infection, looseness of teeth, shifting of teeth, and the possibility of deterioration such that treatment will not be possible in the future.

5. I further understand that periodontal disease is chronic and progressive and, following correction through treatment, may recur and cause further loss of support, periodontal pocketing, and bone loss. Additional periodontal treatment may become necessary and be suggested in the future and/or tooth loss may occur.

6. I understand that success of periodontal treatment is hindered by excessive use of tobacco and alcohol.

7. I understand that during and following the contemplated periodontal surgery or treatment, conditions may become apparent which warrant, in the judgment of my doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment and therefore authorize such treatment modifications or alternatives as may become necessary.

8. I understand that the treatment plan(s) presented to me are, in the opinion of my doctor, the wisest course(s) of treatment. If I agree to pursue treatment, a complete treatment plan will be followed. Partial treatment may not be considered.

9. I further understand that I have the right to either refuse or pursue treatment. During the course of treatment, treatment may be discontinued at the discretion of me or my doctor. In the event of discontinuation of treatment, fees paid for the portion of treatment completed are not refundable.

10. I acknowledge that any questions I have had have been answered for me to my satisfaction.

11. I acknowledge that I have been made aware of the fee that I will be responsible for paying during the course of treatment. I understand that I am fully responsible for payment to my doctor for treatment carried out. My doctor, with associates or hygienists/assistants of his (their) choice, will as they deem necessary, complete required forms and letters to allow me to be reimbursed by my dental insurance company. The doctor(s) and hygienists/assistants assume no responsibility for whether or not insurance coverage is provided and, if so, to what extent.

12. I further understand that if, in the opinion of my doctor(s), with associates or hygienists/assistants of his (their) choice, an excessive amount of clerical work is required for submission of insurance forms or any letters, I will be assessed a fee for this service if I wish to have it done.

_____

PATIENT SIGNATURE

_____

PARENT OR GUARDIAN (IF APPLICABLE)

_____

DATE