Consent for Periodontal Treatment

Patient: _____

Dr. Marvin Budd has recommended that I undergo periodontal surgery. The nature and effect of this procedure has been fully explained to me to my satisfaction. I understand that my gum will be opened to gain access for repair of my condition. **Periodontal surgical materials including bone graft materials (human, bovine, synthetic), membranes, periodontal dressings and/or other materials may be required depending on the nature of my periodontal condition.** Unforeseen conditions and/or surgical events may require a revision in the surgical plan including, but not limited to, extraction of hopeless teeth, or termination of the surgical procedure.

I understand that the success of this treatment varies from individual to individual. Some possible complications include, but are not limited to:

- Infection
- Bleeding, swelling, bruising, or discomfort
- Open spaces
- Tooth looseness and sensitivity

I acknowledge that there exists a risk of failure, relapse, additional treatment or worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

I am aware that alternatives to periodontal surgery include no treatment, extraction of the affected tooth or teeth, and non-surgical scraping of tooth roots/gums. I appreciate that the success of treatment will depend on:

- My diligence in providing the oral self care as recommended by Dr. Budd
- My compliance in taking all medications, as prescribed
- My promptness in attending all post operative and follow up visits
- My strict compliance with the recommended ongoing periodontal maintenance program

By signing below:

- I certify that I have read and fully understand this consent form
- I hereby consent to the treatment recommended
- I agree to be directly responsible for the payment of all of my treatment fees
- I understand that my Dental benefit plan may or may not reimburse me for 100% of the fees
- I have had the opportunity to ask any and all questions regarding this treatment prior to commencing it.

I authorize the use of my records for teaching and promotion purposes. I understand that my identify will kept confidential and not revealed.

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Signature of Patient (or Guardian) **Date**:_____