INFORMED CONSENT FOR LASER PERIODONTAL TREATMENT
or LANAP: LASER ASSISTED NEW ATTACHMENT PROCEDURE

Dr. Marvin Budd, after examination and consultation, diagnosed me with Periodontal disease and has recommended that I undergo Laser Periodontal Surgery.

LANAP Therapy is designed to eliminate or substantially reduce periodontally diseased gum and or pockets to help control or prevent future progression of my disease. The nature and effect of this procedure has been fully explained to me to my satisfaction.

Complications may include infection, bleeding, swelling, discomfort, sensitivity but these are usually milder and less severe than conventional surgery.
I acknowledge that there exists a risk of failure, relapse or additional treatment may be required. Optimum results depends on the individual's response and the compliance with Dr. Budd's post-treatment recommendations for diet, oral hygiene and continued periodontal maintenance.

I am aware that alternatives to Laser Periodontal Surgery includes:

- no treatment
- extraction of the affected teeth
- non-surgical scaling of the roots
- conventional Periodontal Surgery

Non-treatment Risks: Not having any treatment can worsen my periodontal disease and predispose me to premature teeth loss, infection, disease and loss of bone. Lost teeth would require replacement with implants, fixed bridges, or partial/complete dentures.

No Guarantee: Laser Periodontal Surgery is similar to other periodontal therapies and is not guaranteed, but have over a 90% success rate in the first 5 years following LANAP therapy.

By signing below:

- I certify that I have read and fully understand this consent form.
- I agree to follow the written and oral post-operative instructions including post-surgical oral hygiene, and take the prescribed medications.
- I agree to be directly responsible for the payment of all of my treatment fees. I understand that my Dental benefits 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 hereby consent to the treatment that was recommended.

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

_____ Date: _____

Signature of Patient (or Guardian)