Consent for Scaling and Root Planing

Scaling and Root Planing

Patient First Name: _____ Patient Last Name: _____ DOB: _____ Area of the mouth which the treatment/procedure will be performed: UR, UL, LL, LR / Teeth #: _____

The purpose of this document is to provide written information regarding the risks, benefits, and alternatives of the procedures named above. This material serves as a supplement to the discussion you have with the doctor. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask the doctor prior to signing the consent form.

THE PROCEDURE

Scaling and Root Planing, also known as "SRP" is the removal of calculus (tartar), bacterial plaque and toxins, diseased cementum (the outer covering of the root surface), and diseased tissue from the inner lining of the crevice surrounding the teeth (the gingival sulcus). This procedure is performed by a Registered Dental Hygienist (RDH) under the supervision of the doctor. The dental hygienist will use an ultrasonic scaler, which sprays water between the teeth and vibrates at a high frequency, and various hand instruments to loosen and remove the bacterial debris. You have the option to use local anesthesia during your appointment. Local anesthesia is an injection of a numbing agent to relieve pain in your gum tissue and make your procedure more comfortable. You may feel pressure throughout your procedure which can be mildly uncomfortable. At the conclusion of your visit, you will be given a prescription mouth rinse called Chlorhexidine. This is an extremely vital part of your post-operative care and should be used as directed by the doctor and your hygienist.

RISKS

I have been informed of and understand the potential risks related to this procedure include but are not limited to: • Varying lengths and degrees of sensitivity. • Swelling, sensitivity and/or bleeding of the gum tissue. • Infection of the teeth, gum tissues or bone. • Increased spacing between teeth due to removal of hard deposits. • Revealing recessed gums which can cause prolonged sensitivity. • Cracking or stretching of the lips or corners of the mouth • Increased mobility of teeth, if deemed severe enough - a tooth may need to be extracted. • Allergic and/or adverse reaction to anesthetic, medication and/or materials

ANESTHESIA

I have elected to proceed with the anesthesia(s) indicated below:

☐ - None

☐ - Local Anesthesia

☐ - Nitrous Oxide (Laughing Gas)

BENEFITS

It has been explained to me that the purpose of this therapy is to reduce some of the causes and symptoms of active periodontal disease. I understand that although there is no cure for periodontal disease, it can be treated. I understand my condition requires additional treatment that may include additional "deep cleanings", periodontal maintenance, periodontal surgery, and/or antibiotics.

ALTERNATIVES

Declining periodontal scaling and root planning and allowing diagnosed periodontal disease to remain untreated, could be detrimental to my health.

POST-TREATMENT -

☐ I agree to follow all instruction provided to me by this office before and after the procedure including:

• Taking medication(s) as prescribed, practicing proper oral hygiene as recommended by my dental team, keeping all appointments, making return appointments if complications arise, and complete care. • Inform the doctor of any post-operative problems as they arise. • My failure to comply could result in complications or less than optimal results. • I understand if my condition does not improve, I may be referred to a gum specialist called a Periodontist, to discuss further treatment options. • I understand that scaling and root planing is only the first step to treating my periodontal disease. I must follow the instructions given to me and must maintain my oral hygiene at home to the best of my ability.

Consent:

☐ By signing below, I attest to the following: The treatment/procedure has been explained to me and what it is for. I understand how this procedure could help me and also reviewed the associated risks and complications. The alternative treatments have been explained to me that might be done instead, and what would happen if I decline this procedure. I understand that the doctor nor the hygienist cannot guarantee the result of the procedure. All my questions have been answered. I know that I may refuse or change my mind about having this treatment/procedure. I have been offered the opportunity to read the consent form. I hereby give my consent to have this treatment/procedure.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient: _____