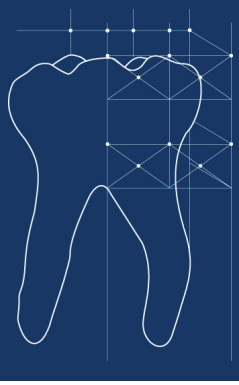

PERIODONTAL (GUM) TREATMENT CONSENT

What you should know about Periodontal Therapy

Perio

CHAVIS DENTAL

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I hereby authorize Doctor _____*(hereinafter called "Doctor") to perform Periodontal Scaling* and Root Planing upon

_____ (Name of Patient)

Diagnosis

I have been informed that I have periodontal (gum) disease and/or periodontal deformities that could lead to the loss of certain teeth. I have been told that the purpose of treatment is to improve the health of my gum tissue, teeth, and their supporting bone. I accept this form as an outline of recommended treatment, its objectives and limitations, and its ordinary after effects.

Treatment Plan

- ❒ Oral hygiene skills development for disease control
- ❒ Scaling and Root Planing (decontaminating and smoothing)
- ❒ Locally Administered Antibiotics (sustained-release minocycline)

Alternatives

Further, I have been informed that possible alternative and/or supplemental methods of treatment include, but are not limited to the following:

- ❒ Extraction(s)
- ❒ Periodontal Maintenance Procedure
- ❒ Flap Surgery with Bone Grafts or Regeneration Techniques
- ❒ Curettage (Surgery)
- ❒ Occlusal Adjustment

Non-Treatment Risks

- ❒ Deepening of periodontal and/or pus pockets
- ❒ Loss of supporting bone
- ❒ Gum recession
- ❒ Loosening of teeth
- ❒ Halitosis
- ❒ Abscesses
- ❒ Loss of teeth
- ❒ Flaring, drifting or other tooth movement

Treatment Risks

The after effects of treatment include, but are not limited to the following:

- ❒ Pains
- ❒ Tooth mobility
- ❒ Gum recession
- ❒ Infection
- ❒ Phonetic interference
- ❒ Swelling
- ❒ Irritation of lip tissue
- ❒ Increased susceptibility to dental decay
- ❒ Food impaction between teeth
- ❒ Unesthetic exposure of crown (cap) margins
- ❒ Temporary restricted mouth opening
- ❒ Numbness of jaw or gum nerves
- ❒ Increased sensitivity to hot or cold

Unforeseen Conditions During Treatment

If any unforeseen condition should arise in the course of treatment, calling for the Doctor's judgment or for procedures in addition to or different from those contemplated, I further request and authorize the Doctor to do whatever he may deem advisable.

No Warranty

Although it is the Doctor's opinion treatment results will be satisfactory, no guarantee or assurance has been given that the proposed therapy will be curative and/or successful to my complete satisfaction. I realize that because of particular patient differences, the risks of failure, relapse, or worsening of my present periodontal condition can occur despite the best of care; and may require re-treatment and/or extraction of teeth. It has been explained to me that the success of treatment is significantly dependent upon long-term and effective daily removal of bacterial deposits (plaque) from my teeth, as well as my adherence to a program of regular-interval periodontal maintenance procedures at our dental office after the proposed active treatment is completed. Treatment may or may not be covered by dental insurance, depending on specific dental insurance contract.

I certify that I have read fully and have had all of my questions answered so that I understand the above consent to treatment, the explanation therein referred to or made, and that all inapplicable items or paragraphs, if any, were stricken before I signed. I understand any check marks by the doctor signify items considered probable in my case and that the remainder continue as applicable possibilities.

Name of Patient (Please Print) _____ (Patient/Parent/Guardian) Signature _____

Date _____Doctor _____ Witness _____