Periodontal Scaling and Root Planing Informed Consent

I voluntarily consent to periodontal scaling and root planing which has been recommended to me. I have been informed that plaque, calculus, diseased soft tissue and possibly diseased hard tissue will be removed from around my teeth.

The scaling and root planing procedure has been fully explained to me. I understand that scaling and root planing does not cure periodontal disease. I understand the risks involved with this procedure and I have been informed that complications might include, but are not limited to:

1. Increased tooth sensitivity due to possible exposure of crown margins and roots after healing and slu·inkage of the gum tissue
2. Pain, bruising and swelling.
3. Additional infection in the involved area and elsewhere may later occur
4. Further loss of bone and gum tissue may later occur
5. Additional periodontal treatment is not covered by the scaling and root planing fee.
6. The treatment may fail and my condition may worsen making a referral toa Periodontist necessary

I have been informed that failing to treat my periodontal disease could result in an increase in infection, loss of bone tissue, loose teeth and loss of teeth altogether.

I understand the consequences of inadequate home care and agree to accept the responsibility to be co-therapist for this treatment. I have been given instructions and recommendations to follow and agree to follow these carefully. I understand that negligence on my part could result in the failure of pe1iodontal treatment.

I further understand that no warranty or guarantee had been made relative to the results that may be obtained by this procedure by any staff member or Dr. Zachary Linkous personal1y.

I understand this consent form and I acknowledge that Dr. Zachary Linkous and staff have answered all of my questions related to the scaling and root planing procedure. I give permission to the dental hygienist and/or dentist to perform this procedure for me.

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Signature of Patient/Guardian Date