CONSENT FOR PERIODONTAL TREATMENT

DIAGNOSIS: After a careful examination and study of my dental condition, Dr. Yaholnitsky has advised me that I have periodontal (gum and bone) disease.

This disease process has been explained to me and I understand it is caused by bacte~al toxins. I understand that periodontal disease weakens support of my teeth by separatmg the gum from the teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum line and can result in further erosion or loss of bone and gum supporting the roots of my teeth. I realize that this disease may be painless and asymptomatic, but that usually symptoms such as bleeding, swelling or recession of gum tissue, loosened teeth, elongated teeth, bad breath, sensitivity and soreness may be noticed. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health. Periodontal disease is the primary cause of tooth loss in adults.

RECOMMENDED TREATMENT: In order to treat this condition, Dr. Yaholnitsky has recommended that my periodontal treatment include periodontal scaling and root planning, either as a therapeutic procedure or preliminary to more extensive treatment. Periodontal scaling and root planning is the removal of calculus, bacterial plaque, bacterial toxins, diseased cementum, and diseased tissue from the inner lining crevice surrounding the teeth. Periodontal scaling and root planning may be either a therapeutic procedure or preliminary to more extensive treatment.

I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment. Systemic antibiotics may be utilized to lower the bacteria in the surrounding gingiva (gum tissue).

I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, 1) extraction of hopeless teeth to enhance healing of adjacent teeth, or 2) periodontal surgery to have better access to the root surfaces of the teeth.

EXPECTED BENEFIT: The purpose and benefit of scaling and root planning, is to reduce infection and inflammation to a level more manageable by my own individual immune system.

PRINCIPAL RISKS AND COMPLICATIONS: I understand that some patients do not resJ?ond succ~ssfully to .scaling .~d root planning. Some of the conditions caused by penodontal disease are irreversible. Because each patient's condition is unique, long term success mav not occur and in such case, some of the involved teeth may eventually be lost. .

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Complications that may result from scaling and root p~~ng could invo~ve t~e, or. anesthetics. These complications include, but are not limited to post-surglcall~fectlon, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and transient (on rarest of occasions permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. The exact duration of any complication cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. There may be a need further procedures if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, snuff and chewing tobacco, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

To my knowledge, I have reported to my periodontist any prior drug reaction, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care, recommended by Dr. Yaholnitsky, and taking all medications prescribed, are important to the success of the procedure.

ALTERNATIVES TO SUGGESTED TREATMENT: I understand the recommended treatment for my periodontal condition.

The consequences of doing nothing or discontinuing treatment may be, but are not limited to: l)Worsening of the disease causing increased bone loss which may lead to the need for teeth to be extracted in the future, 2) Increased infection, bleeding, pain and soreness.

NECESSARY FOLOW-UP CARE AND SELF CARE: It is important for me to continue to see my regular dentist for routine dental care and to get the missing tooth/teeth replaced as recommended.

I u.nderstand smoking and smokeless tobacco may adversely affect healing and may cause pam and/or a poor result, especially if used during the 1st month.

I have told Dr. Yaholnitsky about arty pertinent medical conditions I have known allergies (especially to medications), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Yaholnitsky about any present or prior head and neck radiation therapy.

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I have told Dr. Yaholnitsky about any present or prior use ofbisphosphonate medications. Some common brand names are Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®.

I need to come back in for several post-operative check-ups so that healing may be monitored and so Dr. Yaholnitsky can evaluate and report on the outcome of surgery to my dentist. It may be necessary to remove both non-resorbable sutures and non-resorbable membranes used in the bone regeneration surgery.

I know that it is important to:
1. Abide by the specific prescriptions and instructions given.'
2. See Dr Yaholnitsky for post-operative check-ups as needed.
3. No smoking or use of smokeless tobacco for 1 month.
4. Get the tooth/teeth replaced as recommended.

NO WARRANTY OR GUARANTEE: While in most cases the surgical area heals quickly and with out any problems, complications such as those listed previously, can happen despite the best of care.

PUBLICATION OF RECORDS: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry, in written or internet publications or sites, and in promotional materials. My identity will not be revealed to the general public.

Procedure(s) to be performed:
PATIENT CONSENT: I have been informed of the nature of this periodontal treatment, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had and opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Yaholnitsky and his staff members. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Y aholnitsky.

Date [Printed name of patient, parent or guardian]

[Signature of patient, parent or guardian]

Date [Printed name of witness]

[Signature of witness]