Dental Specialists Of Texas, P.A.
Compassionate Care with a Personal Touch
Hiru Mathur, D.D.S., M.S., Diplomate
15200 Southwest Freeway, Suite 120, Sugar Land, TX 77478
Phone: (281) 494-2477 Fax: (281) 494-2487

CONSENT FOR NON-SURGICAL PERIODONTAL THERAPY

I hereby authorize ____________________________ (hereinafter called Doctor and/or

Hygienist) to perform Non-Surgical Periodontal Therapy (Scaling and Root Planning)

upon:____.
(Name of Patient)

The Doctor had advised me that the diagnosis indicates I suffer from a condition known as Periodontitis (Periodontal Disease).

I have been informed that the purpose of this treatment is to improve my periodontal condition by removing bacterial plaque and calculus (calcified plaque) found in the periodontal pocket(s) and on the root surface(s). ***This procedure is effective in the management of Early to Moderate Periodontitis, but may not be a definitive treatment, especially in deep pocketing sites. The Doctor and/or Hygienist will re-examine the periodontal pocket site(s) at the follow-up appointment (4 wks after srp) to determine the need for further treatment.***

Further, I have been informed that other possible alternative and/or supplemental methods of treatment exist to include, but are not limited to: prophylaxis (cleaning above the gum line) alone, Antibiotic therapy with topical or systemic agents, occlusal adjustment (selective grinding of the teeth), and/or tooth extraction (removal).

Post-operative risks of the proposed treatment include, but are not limited to: swelling; infection; tooth sensitivity; pain; restricted mouth opening for several days, weeks, months, or longer; paresthesia (numbness) of the jaw or gum nerves which may persist for several weeks, months, or in remote instances, permanently; gum recession (shrinkage, teeth appearing to be longer than before); temporary, or in rare instances, permanently; gum recession (shrinkage, teeth appearing to be longer than before); temporary, or in rare instances, permanent interferences with phonetics (speech sounds); clicking or pain of the temporomandibular joint (jaw joints); tooth sensitivity to hot or cold for days, weeks, months, or on occasion permanently; transient, or in some instances permanent tooth mobility (looseness) in selected areas; food lodging between the teeth after meals, requiring cleaning devices such as floss for removal; and unesthetic exposure of crown (cap) margins.

I further understand that if no treatment is rendered, my present periodontal condition will worsen and may result in tooth loss.
I know the practice of dentistry is not an exact science and that reputable Practitioners cannot guarantee results.

No guarantee, warranty or assurance has been given to me by anyone that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my condition to include the possible extraction of certain involved teeth despite the best of care. However, it is the Doctor's opinion that therapy will be helpful, and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment.

I understand that long-term success requires my long-term continued performance of mechanical plaque removal (oral daily homecare) and my availability for periodic maintenance visits (recall professional care).

I ____ Do _____Do Not consent to photographs of my oral and facial structures and their publications for educational and scientific purposes.

I am executing this Authorization and Informed Consent to Non-Surgical Periodontal Therapy (Scaling and Root Planning) on behalf of _______________________________. In so doing, I have advised the Doctor and/or Hygienist that I am the patient's guardian (or closest available relative). As such, I am authorized to execute this consent on his/her behalf.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT. THE EXPLANATION THERIN REFERRED TO OR MADE AND ALL NON-APPLICABLE PARAGRPHS, IF ANY WERE STRICKEN BEFORE I SIGNED.
I CONSENT TO THE FOLLOWING TREATMENT: ________________________

____

_________________________ Date

_______________________________ (Printed Name of Patient, Parent, or Guardian)

_______________________________ (Signature of Patient, Parent or Guardian)

_________________________ Date

_______________________________ (Printed Name of Witness)

_______________________________ (Signature of Witness)