



## Portway Dental Practice

### Discussion and Consent for Periodontal (Gum) Treatment

#### Patient’s Information

Surname [ ]

Forename [ ]

Date of Birth [ ]

Address [ ]

I am being provided with this information and consent form so I may better understand the treatment recommended for me. Before beginning, I wish to be provided with sufficient information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may ask any questions I wish, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

#### Nature of the Recommended Treatment

It has been recommended that I have the following periodontal treatment (all that apply have been checked for me):

- Scaling and root planning
- Osseous (bone) surgery and recontouring
- Gingivectomy (recontouring)
- Periodontal bone graft
- Soft tissue graft
- Referral to a gum specialist (periodontist)
- Other [ ]

Teeth or areas of each recommended treatment: [ ]

This recommendation is based on visual examination, periodontal probing and charting, X-rays, other diagnostic tests, any models or photos taken, and on my doctor’s knowledge of my medical and dental history. The treatment is necessary because of periodontal (gum) disease that has been diagnosed as:

- Generalized chronic periodontitis
- Localized chronic periodontitis
- Gingivitis/gingival disease
- Generalized aggressive periodontitis
- Localized aggressive periodontitis
- Other (as specified): [ ]



Teeth or area that applies to each diagnosis: [ ]

I have been informed that periodontal diseases are infections that affect the tissues and bone that support teeth. I have been informed that other factors can affect my periodontal disease and its progression, including the condition of my dental restorations, certain diseases (such as diabetes and heart disease), habits (tobacco use), and medications.

Factors specifically affecting me include: [ ]

The intended benefit of this treatment is to improve the health of my gums and teeth and to try to retain my natural teeth as long as possible. Other benefits may include: [ ]

The prognosis, or likelihood of success, of this treatment is: [ ]

My treatment is estimated to take [ ] visits to complete, and is estimated to cost £ [ ].

### Alternative Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative ways to treat my periodontal dental condition include: [ ]

No other reasonable treatment option exists for my condition.

[Forename/Surname], I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including [ ].

### Risks of the Recommended Periodontal Treatment

I understand that no dental treatment is completely risk-free and that my dentist would take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include tooth sensitivity, pain from treatment, infection, swelling, dark spaces between teeth where there is no longer any gum tissue, and changes in how long my teeth appear (due to recontouring). I understand that as the health of my gum tissue improves, the tissues may shrink or recede: this is a normal reaction to treatment. This change may make some previous dental restorations (crowns, fillings) more noticeable and they may need to be replaced to make them more cosmetically acceptable. I understand that I may be given a local anaesthetic injection and that in rare situations, patients have had an allergic reaction to the anaesthetic, an adverse medication reaction to the anaesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anaesthetic injection. Other risks of my treatment include:

### Risks of Not Having the Recommended Periodontal Treatment

I understand that complications to my teeth, mouth, and/or general health may occur if I do not proceed with the recommended treatment. These complications include:



- Pain
- Bleeding
- Swelling
- Mouth odor
- Tooth mobility
- Tooth loss
- Additional infection
- Complication of other health issues (such as diabetes, heart disease, stroke)
- Inability to proceed with other dental care
- Other: [ \_\_\_\_\_ ]

[Forename/Surname], I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about.

### **Acknowledgment**

I, [Forename/Surname], have received information about the proposed periodontal treatment. I have discussed my treatment with Dentist and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

### **I wish to proceed with the recommended periodontal treatment.**

[Forename/Surname], I understand this treatment can also be performed by a periodontist (a specialist in the treatment of periodontal disease and placement of dental implants). I understand the risks and elect to have this procedure performed by Dentist [ \_\_\_\_\_ ]. I understand that if any unexpected difficulties occur during treatment, I may be referred to a periodontist for further care.

**Forename**

**Surname**

**Signed**