Statement of Informed Consent to Periodontal Treatment

This is my consent for Drs. Albright, Burton, and Shearer and auxiliary personnel employed by them to perform all necessary periodontal therapy procedures as indicated on my examination chart. These may include examination, prophylaxis (cleaning), home care (plaque control) instructions, scaling and root planing (deep cleaning), biopsy, occlusal equilibration (bite adjustment), application of desensitizing medication, antibiotic treatment, periodontal surgical procedures as previously explained to me and any other procedure deemed necessary or advisable as a corollary to these planned procedures. I also agree to the use of a local anesthetic, or nitrous oxide sedation, depending on the judgment of the doctors, as well as any prescription medication.

I have been informed and understand that occasionally there are complications of the periodontal therapeutic procedures, drugs and anesthesia. These include root exposure and sensitivity to hot, cold and sweets, pain, infection, swelling, bleeding, discoloration, numbness, tingling and trauma to the tongue and lips, change in occlusion (bite), loosening of teeth, injury to other tissues, nausea and vomiting, allergic reactions, delayed healing, and sinus complications.

Medications, prescription drugs and anesthetics may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous device until fully recovered from these drugs. This includes any preoperative relaxant medication given to me prior to surgical procedures and narcotic pain reliever drugs prescribed for me after periodontal surgery.

I realize that I will receive and understand postoperative instructions, will be given an appointment date to return, and may telephone this office at any time if questions or problems arise. It has been explained to me, and I understand there is no warranty or guarantee as to any result and that there is no cure for periodontal disease. I understand I can ask for a full review of all possible risks associated with my care by just asking.

____________________________________________  __________________
Print Name                                         Date

____________________________________________
Signature                                          

____________________________________________  __________________
Reviewer                                          Date