

# Informed consent for periodontal root planing and scaling

I understand that periodontal procedures (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. Even when the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions through scaling and root planing, risks and results associated with treatment include but are not limited to the following:

**1. Response to treatment**

Because of the variables within each patient's physiological makeup, it is impossible to determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by Dr. \_\_\_\_\_ and the patient. Should the desired results not be attained, extractions may be required.

**2. Postoperative patient responsibility for care**

With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist. Without the necessary follow-up care, the probability of unsatisfactory results is greatly increased.

**3. Pain, soreness and sensitivity**

There may be temporary or permanent postoperative discomfort, related to hot and cold stimuli, contact with teeth, and sweet and sour foods, and the gums also may be sore immediately following treatment.

**4. Bleeding during or after treatment**

Laceration or tearing of the gums may occur and might require suturing. The gums may bleed as well, during or after treatment.

**5. Recession of the gums after treatment**

After healing occurs, there may be gum recession that exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, and creates aesthetic or cosmetic changes in the front teeth, resulting in longer tooth appearance and wider inter-proximal spaces. These wider inter-proximal spaces are more likely to trap food.

**6. Broken curettes, scalers or other instruments**

If an instrument breaks off during scaling or root planing, it may be necessary to retrieve the broken instrument surgically.

**7. Post-treatment infection**

Post-treatment infection also can result from calculus being lodged in the tissue, which also can require surgical intervention.

**8. Increased mobility (looseness) of the teeth during the healing period**

Some patients experience increased mobility of teeth during the healing period. This is usually a temporary condition.

**9. Noise and water spray**

Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on nonanesthetized teeth not being treated.

**10. Post-treatment complications**

Cracking or stretching of the lips or corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planing.

**11. Sequela of local drug delivery**

If tetracycline fiber is used, there may be premature loss of the fibers necessitating a return visit to the dental office for replacement. There may be soreness or pain in the treated areas. The patient will be aware of the adhesive sealer, which often has a granular surface. The sealer has an opaque or milky appearance that may be visible. There will be a need for a postoperative visit to remove the fibers seven to 10 days after placement. There may be an adverse reaction to the antibiotic in the fiber, whether a pre-existing known allergy exists or not.

**Informed consent**

I have been given the opportunity to ask questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I voluntarily assume any and all known possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of this treatment. The fee(s) for this service have been explained to me and are acceptable. By signing this form, I am freely giving my consent to allow and authorize Dr. \_\_\_\_\_ and/or his/her associates to render any treatment necessary or advisable for my dental conditions, including any and all anesthetics and/or medications.

\_\_\_\_\_ Date \_\_\_\_\_  
*Patient signature*

\_\_\_\_\_  
*Printed name*

\_\_\_\_\_ Date \_\_\_\_\_  
*Witness signature*