DR.KATBAB DENTISTRY

Patient's name (please print) _____

INFORMED CONSENT PERIODONTAL SURGERY

The surgical phase of periodontal therapy seeks to (1) improve the prognosis of teeth and/ or (2) improve aesthetics. It consists of techniques performed for periodontal pocket therapy and for the correction of related morphological problems. The purpose of surgical pocket therapy is to eliminate the pathological changes in the pocket wall; to create a stable, easily maintainable state; and if possible; to promote periodontal regeneration.

I understand that the procedures that Dr. _____ will be performing on me will include:

PROCEDURES	LOCATION	FEE

Alternative treatment options have been discussed with me. If the present periodontal condition persists without surgeries or other appropriate treatments, the risks to my dental health may include, but not limited to, the following:

- Premature loss of teeth
- Halitosis (bad breath)
- Periodontal abscesses (pus)
- Continuing gum recession
- Loosening of teeth
- Damage to the nerve of teeth
- Further deepening of periodontal pockets
- Tooth drifting, flaring, or other pathological tooth migrations

There are certain inherent and potential risks in any treatment plan/ surgical procedures. In this specific instance, the risks may include, but are not limited to the following complications:

- Infection of the surgical site
- Swelling
- Gum recession
- Tooth mobility
- Food impaction between teeth
- Permanent of temporary nerve damage
- Pain and discomfort
- Exposure of margins of crowns
- Tooth sensitivity to hot and/ or cold
- Temporary restricted mouth opening
- Others _____

Due to some unforeseen conditions, Dr. _____ may discover unknown conditions, for which good surgical procedure dictates should be remedied and attended to at that time. I therefore consent to the performance of such additional or alternative procedures as may be indicated by good surgical care.

I understand, however, that because of the nature of the proposed treatment/ procedures and the uniqueness of every case, one cannot predict the certainty of success. I understand and appreciate this fact, and hereby acknowledge that no guarantee warranty or assurance has been given to me that the proposed treatment and/or procedure will be curative or successful to my complete satisfaction. I have been told that the success of the recommended treatment depends upon my cooperation in keeping the scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, and reporting to the office my unanticipated reactions following the surgeries.

I also agree to the use of topical and local anesthetic analgesia as the dentist's judgment finds necessary in my case. I am aware of the possible consequences with this surgical procedure, anesthesia, and the use of therapeutic drugs as outlined by the dentist including swelling, bleeding, discomfort, bruising, nausea, increased temperature, dental infection, possible paresthesia (numbness), possible dysesthesia (altered sensation), increased tooth sensitivity, aesthetic changes (appearance, length of teeth, increased spacing between teeth etc.), and possible increased tooth mobility.

I have been informed that periodontal surgery is intended to extend the length of tooth retention and that no prognosis can be designated to each tooth and furthermore, that any tooth (teeth) having questionable prognosis may require extraction after surgical evaluation and treatment.

It has been explained that I must maintain diligent and consistent home care, obtain frequent cleanings and proper oral rehabilitation in order to increase tooth longevity.

To my knowledge, I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reaction to drugs, food, anaesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I also realize that I am fully responsible for complete and proper payment of my account upon completion of the surgical procedure regardless of insurance coverage payment for my treatment.

I understand that this Consent to Treatment form and the treatment provided as described above be governed by the laws of the Province of and I consent to the Courts of the Province of having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment, whether based on alleged breach of contract or alleged.

Negligence in providing such treatment or on any other grounds whatsoever, and whether against the dentist(s) named in above or against any of his/her partners, associates, employees or staff.

I undertake and agree to not commence any action relating to such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment, or on any other grounds whatsoever, in any other legal jurisdiction outside of the Province of whether or not I may have a right to do so.

I acknowledge and understand that Dr. _____ has agreed to provide professional services for me conditional on this undertaking being given and honoured by me with regard to my declaring that the Province of has exclusive jurisdiction over any action, suit or proceeding and Dr. has

made it clear that without my making this undertaking, he would not have agreed to provide treatment for me.

I confirm that I have discussed the estimated cost, future costs and method and terms of payment for the treatment described in above with Dr._____ and that I have agreed to make such, payment on the terms we discussed.

BY INITIALING HERE "_____ ", I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT. I ALSO CERTIFY THAT I WAS GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAS BEEN SATISFACTORILY ANSWERED. BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING OF THE INFORMATION ABOVE AND THAT I AGREE TO PROCEED WITH TREATMENT AS PROPOSED.

Print Name:_____

Signature of Patient: _____
Or Signature of Parent of Guardian (or other person authorized to consent for patient)

Relationship of Person Signing to Patient: _____
Note: When a patient is a minor and/or is otherwise incapable of consenting to the treatment, the consent of a parent, guardian or substitute decision maker must be obtained.

Date: _____

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness_____

Doctors Name_____ Doctors Signature: _____