

Informed Consent

General Periodontal Treatment

I authorize Dr. Byers and his or her associates, hygienists, employees, and agents to perform periodontal treatment for me as recommended:

After a thorough examination and diagnosis, I have been informed of the recommended treatment plan, alternative treatment, and the benefits and risks involved. I have also been informed of the risks of inadequate or non-treatment, and the fee(s). All of my questions have been answered to my satisfaction.

I understand that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of my periodontal treatment. A risk of failure, relapse, or worsening of my periodontal condition may result regardless of the efforts made during treatment. Additional or re-treatment is always a possibility. I recognize that long term success depends upon my cooperation and routine maintenance as well.

I specifically authorize my dentist to select alternative methods of treatment based on my condition even during the treatment described in this form, including treatment for conditions which were unknown at the time my periodontal treatment began.

I understand that there are substantial risks and consequences that may be associated with any surgical, dental, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed, but that the following possibilities exist, however infrequent or rare:

- Excessive bleeding • Pain • Temporary or permanent numbness of the lip, tongue, or other facial area • Jaw fracture • Swelling • Infection • Allergic reactions to medications, anesthesia, or others • Bruising • Gum recession with "longer" appearing teeth • Exposure of crown margins • Sensitivity • Food impaction areas • Speech changes

Knowing these risks I consent to treatment.

Patient Signature _____ Date _____

Dr Byers _____