Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

Periodontal Treatment

Patient Name: _____ Date: _____

I understand that I have periodontal (gum and bone) disease. This disease process has been explained to me and I understand it is caused by bacterial toxins. I realize that this disease is painless and asymptomatic, but that usually symptoms such as bleeding, swelling or recession of gum tissue, loosened teeth, bad breath, sensitivity and soreness may be noticed. Treatment of periodontal disease may include periodontal scaling and root planning, either as a therapeutic procedure or preliminary to more extensive treatment. Periodontal scaling and root planning is the removal of calculus, bacterial toxins, diseased cementum, and diseased tissue from the inner lining crevice surrounding the teeth.

I understand:

- The purpose and benefit of this procedure is to reduce some of the causes of periodontal disease to a level of more manageable by own individual immune system.
- My own efforts with home care are just as important as my professional treatment.
- Some of the conditions caused by periodontal disease are irreversible.
- Maintaining regular periodontal cleanings is essential.
- Future re-treatment of scaling and root planning may be necessary.

The consequences of doing nothing or discontinuing treatment may include, but are not limited to the following:

- Worsening of the disease causing increased bone loss which may lead to the need for teeth to be extracted in the future.
- Increased infection, bleeding pain and soreness.
- Possible systematic problems: Heart Disease, Stroke, Diabetes, Respiratory Disease, etc.

The treatment risks may be, but are not limited to:

- Increased recession of the gum tissue and exposure of root surfaces as the tissue heals, and swelling decreases.
- Some pain, swelling or bruising may be experienced after treatment.
- Increased sensitivity to hot, cold, or sweets. (This may require further treatment, may fade with time, or may persist no matter what is done.

I understand the recommended treatment for my periodontal condition. Alternative treatment has been explained to me as well as the consequences of not receiving treatment.

[ ] I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

[ ] I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

X_____ Date: _____

Patient Signature

Hygienist/Assistant Initials: _____