Discussion and Refusal of Periodontal (Gum) Treatment

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Patient's Name ____ Date of Birth ________________________
Last First Initial

I am being provided this information and refusal form so I may fully understand the treatment recommended for me and the consequences of my refusal. I wish to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may **ask any questions I wish** regarding the recommended treatment.

Nature of the Recommended Treatment

It has been recommended that I have the following periodontal treatment (all that apply have been checked for me):

ˆ ☐ Scaling and root planing ˆ ☐ Osseous (bone) surgery and recontouring ˆ ☐ Gingivectomy (recontouring)
ˆ ☐ Periodontal bone graft ˆ ☐ Soft tissue graft ˆ ☐ Referral to a gum specialist (periodontist)
ˆ ☐ Other: ____

Teeth or areas of each recommended treatment: ____
____

This recommendation is based on visual examination, periodontal probing and charting, x-rays, other diagnostic tests, any models or photos taken, and on my doctor's knowledge of my medical and dental history. The treatment is necessary because of periodontal (gum) disease that has been diagnosed as:

ˆ ☐ Chronic generalized periodontitis ˆ ☐ Chronic localized periodontitis ˆ ☐ Gingivitis/gingival disease
ˆ ☐ Aggressive generalized periodontitis ˆ ☐ Aggressive localized periodontitis ˆ ☐ Other (as specified)

Teeth or area that applies to each diagnosis: ____
____

I have been informed that periodontal diseases are infections that affect the tissues and bone that support teeth. I have been informed that other factors can affect my periodontal disease and its progression, including the condition of my dental restorations, certain diseases (such as diabetes and heart disease), habits (tobacco use), and medications.
Factors specifically affecting me include: ____

The intended benefit of this treatment is to improve the health of my gums and teeth and to try to retain my natural teeth as long as possible. Other benefits may include: ____
____

The prognosis, or chance of success, of this treatment is: ____

My treatment is estimated to take _____________ visits to complete.
My treatment is estimated to cost $_____________.

Patient: ___________________________________

Alternative Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative ways to treat my periodontal dental condition include: ______________________________________
____

☐ No other reasonable treatment option exists for my condition.

Risks of the Recommended Periodontal Treatment

I understand that no dental treatment is completely risk-free and that my dentist would take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include tooth sensitivity, pain from treatment, infection, swelling, dark spaces between teeth where there is no longer any gum tissue, changes in how long my teeth appear (due to recontouring), and the need to replace previous dental restorations due to changes in the position of my gums due to treatment. Other risks of my treatment include: ____

Risks of Not Having the Recommended Periodontal Treatment

I understand that complications to my teeth, mouth, and/or general health may occur if I do NOT proceed with the recommended treatment. These complications include:

☐ Pain ☐ Bleeding ☐ Swelling ☐ Mouth odor ☐ Tooth mobility ☐ Tooth loss
☐ Additional infection ☐ Complication of other health issues (such as diabetes, heart disease, stroke)
☐ Inability to proceed with other dental care ☐Other: _______________________________________

____________ I have had an opportunity to ask questions about these risks and any other risks I have heard or
Patient's Initials thought about.

Acknowledgement

I, _______________________________, have received information about the proposed periodontal treatment. I have discussed my treatment with Dr. _________________________ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and my refusal of care.

I personally assume the risks and consequences of my refusal, and release for myself, my heirs, executors, administrators, or personal representatives those dentists who have been consulted in my case from any and all liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

I do NOT wish to proceed with the recommended periodontal treatment.

Signed: ____ Date: ______________________________
Patient or Guardian

Signed: ____ Date: ______________________________
Treating Dentist

Signed: ____ Date: ______________________________
Witness