AUSTIN PERIODONTAL ASSOCIATES: Dr. Andrew D. Verrett

CONSENT FOR NON-SURGICAL PERIODONTAL TREATMENT (SCALING AND ROOT PLANING)

I _____ (Name of patient) hereby authorize Dr. Andrew Verrett and Team to perform non-surgical periodontal scaling and root planing. I have been informed that the purpose of this procedure is to treat and possibly correct my diseased gum tissues, teeth, implant and/or supporting jawbones. I have been informed of other possible alternative and/or supplemental methods of treatment. Post-operative risks of the proposed treatment include, but are not limited to, pain, paresthesia (numbness) from anesthetic injections, which may persist for several weeks or in rare instances permanently; gum recession (shrinkage); clicking, limited opening, or pain of the temporomandibular joints (TMJ-jaw joints); sensitivity to hot or cold, tooth mobility (looseness); food lodging between the teeth after meals which may require special cleaning devices; and exposure of crown margins of teeth in the treatment areas.

I understand that if no treatment is rendered then my present periodontal condition will probably worsen in time, which may result in premature tooth and/or implant loss.

No guarantee, warranty or assurance have been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment or worsening of my present condition despite the best of care. However, it is Drs. Verrett and/ or team's opinion that therapy will be helpful and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment. I understand that success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic periodontal maintenance (cleaning) and visits (recall professional care).

I HAVE BEEN FULLY INFORMED OF THE SURGICAL PROCEDURE, BENEFITS, RISKS AND ASSOCIATED PROCEDURES. I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND HAVE HAD ADEQUATE TIME TO REVIEW THIS DOCUMENT. I WILL COMPLY WITH THIS DOCUMENT AND MY PERIODONTIST/STAFF HAS ANSWERED ALL MY QUESTIONS TO MY SATISFACTION.

Patient's Printed Name	Signature	Date
Witness Printed Name	Signature	Date
Doctor's Printed Name	Signature	Date