Patient Consent to Periodontal Therapy

1. I hereby authorize Dr. Robert Solomon to remedy or treat the condition or conditions which appear indicated by diagnostic studies.
2. The procedures recommended to remedy or treat my condition have been explained to me and I understand the nature of the procedure to include periodontal therapy which may consist of scaling, root planning, curettage, occlusal adjustment and/or periodontal surgery, including bone grafts and regeneration, and tooth extraction.
3. It has been explained to me that, during the course of therapy, unforeseen conditions may be revealed that necessitate an extension of the original procedures or different procedures than those set forth in Paragraph 2. I therefore authorize and request that the above named doctor, his/her assistants, and designees perform such procedures as are advisable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all conditions that in the judgment of the doctor requires treatment and are not known to him/her at the time therapy is commenced.
4. I consent to the administration of such local anesthetics and analgesic drugs as may be considered necessary or advisable by the doctor.
5. I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during the consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.
6. NO WARRANTY OR GUARANTEE. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a therapist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth or implants, despite the best care.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Date__________________ Print________________________________
Signature________________________

Name of Patient/Parent/
Guardian

Witness_________________________________Signature__________________

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