

Periodontal Scaling and Root Planing Informed Consent

I _____ (print patient name)
voluntarily consent to periodontal scaling and root planing which has been recommended to me.
I have been informed that plaque, calculus, diseased soft tissue and possibly diseased hard tissue
will be removed from around my teeth.

The scaling and root planing procedure has been fully explained to me. I understand that
scaling and root planing does not cure periodontal disease. I understand the risks involved with
this procedure and I have been informed that complications might include, but are not limited to:

increased tooth sensitivity due to possible exposure of crown margins and roots
after healing and shrinkage of the gum tissues
pain, bruising and swelling
additional infection in the involved area and elsewhere may later occur
further loss of bone and gum tissue may later occur
additional periodontal treatment may be necessary if my periodontal condition is
determined to be worse than previously thought. I understand that
additional periodontal treatment is not covered by the scaling and root
planing fee.
the treatment may fail and my condition may worsen making referral to a
periodontist necessary

I have been informed that failing to treat my periodontal disease could result in an
increase in infection, loss of bone tissue, loss of gum tissue, loose teeth and loss of teeth.

I understand the consequences of inadequate home care and agree to accept the
responsibility to be co-therapist for this treatment. I have been given instructions to follow and
agree to follow the instructions carefully. I understand that negligence on my part could result in
the failure of periodontal treatment.

I further understand that no warranty or guarantee has been made relative to the results
that may be obtained by this procedure by any staff member or dentist with the Atlanta Dental
Group PC.

I understand this consent form and I acknowledge that the Atlanta Dental Group PC staff
have answered all of my questions related to the scaling and root planing procedure. I give
permission to the dental hygienist and/or dentist to perform this procedure for me.

Patient (or Guardian) Signature:

Dental Staff Signature: