

LIONELL N. GREENBERG, D.D.S.
A PROFESSIONAL CORPORATION

THOMAS N. SIMS, D.D.S.
A PROFESSIONAL CORPORATION

CONSENT TO PERIODONTAL TREATMENT

This informed consent is given to Dr. Greenberg or Dr. Sims, hereafter referred to as Doctor, after first having had an explanation of the nature of the proposed treatment, the alternatives and the risks. Doctor has advised me that from the dental examination that I have received, I have the following diagnosis.

Treatment: I hereby authorize and consent to Doctor and whomever he may designate to perform the following procedure:

I elect to treat my condition by the proposed treatment rather than any alternative therapy.

Alternative treatments: In making the above recommendations, Doctor has advised me that alternative treatments exists which may include, but are not necessarily limited to: frequent scaling and root planing, surgical curettage, cleanings, oral hygiene instructions and evaluation, tooth extractions, dentures, implant treatments, consistent maintenance therapy.

Non-treatment risks: Doctor has advised me that no treatment may result in health risks. If this periodontal condition persists and is not corrected, the risks may include, but are not necessarily limited to: premature tooth loss and the need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, abscesses or infections, pain, poor chewing, tooth sensitivity, tooth movements, worsening of periodontal disease.

Treatment risks: I also understand that inherent to any procedure, and because of individual's variations, certain potential risks are involved with this treatment. These may include: temporary swelling, bleeding, intermittent pain, nausea, hot or cold tooth sensitivity, gum recession, exposure of crown margins, temporary speaking difficulties, infections, tooth mobility, food impaction, root canal therapy, joint pain/disorder.

I have received an opportunity to ask any questions about the proposed treatment and all questions that I have asked have been answered to my complete satisfaction before this consent was signed.

I also understand that the proposed treatment contains no guarantee or warranty of success. Each individual case is unpredictable, making it impossible to predict results. Therapeutic results are always dependent on individual compliance. I understand for successful periodontal results and to lessen the dangers of complications, the following treatment conditions are required of me: excellent oral hygiene, consistent maintenance appointments, proper diet and strict adherence to instructions in the wearing of any appliances.

In the event of any claim, controversy or dispute, the essential nature of which involves personal injury, malpractice, or any tort, by patient, his dependents, whether or not minors, heirs at law, or personal representatives against Doctor, the sole method for resolving such dispute shall be binding arbitration administered by the American Arbitration Association. Both parties are giving up their right to have such disputes decided in a court of law before a jury.

I certify that I have read and understand this authorization for proposed treatment, medication or surgery described above. I accept the risks in hopes of obtaining the desired beneficial result.

Patient/Guardian _____ Witness _____

Doctor _____ Date _____

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