Summit View Periodontics
Consent for Scaling and Root Planing with Diode Laser Debridement

I **UNDERSTAND** that **PERIODONTAL PROCEDURES** (treatment involving the gum tissues and other supporting the teeth) includes risks and possible unsuccessful results from such treatment. Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions through scaling and root planing and related procedures, there are no promises or guarantees as to the anticipated results. I agree to assume those risks and possible unsuccessful results associated with, but not limited to, the following:

1. **Response to treatment**: Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by both my Periodontist and the patient. Should the desired results not be attained, additional therapy or extractions may be required.
2. **Postoperative patient responsibility for care**: With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist. Without the necessary follow-up care by the patient, the probability of unsatisfactory results is greatly increased.
3. **Pain, soreness and sensitivity**: There may be post-operative discomfort which may be transitory or permanent, related to hot and cold stimuli, contact with teeth, and sweet and sour foods. The gums will also be sore immediately following treatment. Cracking or stretching of the lips/corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planing.
4. **Bleeding during or after treatment**: Laceration or tearing of the gums may occur which might require suturing. The gums may bleed as well during or after treatment.
5. **Recession of the gums after treatment**: After healing occurs, there may be gum recession which exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, creates esthetic or cosmetic changes in front teeth which results in longer teeth and wider interproximal spaces visible as a black triangle. These wider interproximal spaces are more likely they are to trap food.
6. **Broken curettes, scalers or other instruments, and post-treatment infections**: It may be necessary to retrieve broken instruments surgically. Post treatment infection may also result from calculus being lodged in the tissue which may also require surgical intervention.
7. **Increased mobility**, or tooth looseness, should be anticipated during the healing period.
8. **Noise and water spray**: Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on anaesthetized teeth not in the treatment field. The aspiration of fluid and foreign material is possible. My Periodontist and their staff will take measures to minimize your risk of aspiration or swallowing of fluids and aerosols. Most hearing aids are sensitive to the high pitches created by ultrasonic scaling devices. It is recommended that you remove, turn off, or lower the volume of these devised prior to therapy.
9. **Local anesthetic administration:** I understand that the administration of local anesthesia ("numbing solution") and its performance carries certain risks, hazards, and unpleasant side effects which are infrequent, but nonetheless may occur. They include, but are not limited to nerve damage or paresthesia, increased heart rate and/or a flushed feeling, allergic reaction (including death in rare circumstance), hematoma or swelling near or at the injection site, trismus or difficulty opening jaw for a short time after the injection, facial paralysis, soft

tissue damage after the dental procedure due to biting of tongue and cheek, or burning tissues with hot food or beverage while still numb, infection, sloughing of tissue, ocular complications, and needle breakage.

10. **Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during the treatment period.
11. **Diode laser debridement:** In order to treat my periodontal condition, Dr. Sakkaris has recommended that my treatment include laser debridement utilizing the DioDent 980 diode laser. During the laser periodontal procedure, the diode laser will be used to disinfect and decontaminate your gum tissue and also allow for better access to the root surfaces so that they may be thoroughly cleaned with piezoelectric (piezo) ultrasonic scalers and hand scalers. Piezo scalers have been known to adversely affect how some cardiac pacemaker functions, and it may be necessary to consult with your cardiologist prior to therapy. The laser will then be used again (a second laser debridement process) to remove any remaining bacteria in the gum pocket. The final step of the debridement process requires the establishment of a stable blood clot along the gum-tooth junction to "seal" the area for periodontal healing. Occlusal (bite) adjustments and equilibration (which has been explained to me in detail) may be necessary during the procedure. Occlusal adjustments may also be performed at subsequent post-op visits and wearing an occlusal guard may also be recommended. Patient compliance is extremely important here. The use of antibiotics and anti-microbial rinses is also an important part of the procedure and must be taken as prescribed.
12. **Lasers and Your Vision:** The Powerlase AT and DioDent 980 lasers are classified as tissue cutting lasers and pose a significant risk to your eyes. These lasers are very powerful and can travel for great distances through air, non-filtering glass and semi-transparent materials. You must understand that it is essential to wear your protective eye wear at all times during the procedure and you will only remove them when directed by the doctor. Vision damage from these lasers may be debilitating and permanent.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be obtained. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Sakkaris and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

_____	_____	_____
Date	(Signature of patient/parent/guardian)	(Printed name of patient/parent/guardian)
_____	_____	
Date	(Doctor's signature)	
_____	_____	_____
Date	(Signature of witness)	(Printed name of witness)