

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

I am being provided this information and refusal form so I may fully understand the treatment recommended for me and the consequences of my refusal. I wish to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may ask any questions I wish regarding the recommended treatment.

### NATURE OF THE RECOMMENDED PERIODONTAL TREATMENT

It has been recommended that I have the following periodontal treatment:

- Gingivectomy (Gum Recontouring)    Osseous Bone Surgery    Periodontal Bone Graft    Scaling and Root Planning  
 Soft Tissue Graft    Referral to a Periodontist (Gum Specialist)

The areas of recommended treatment are: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This recommendation is based on visual examination, periodontal probing and charting, x-rays, other diagnostic tests, any models or photos taken, and on my dentist's knowledge of medical and dental history. The treatment is necessary because of periodontal (gum) disease that has been diagnosed as:

- Aggressive Localized Periodontitis    Aggressive Generalized Periodontitis    Chronic Localized Periodontitis  
 Gingivitis    Other: \_\_\_\_\_

The areas that apply to each diagnosis are: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have been informed that periodontal diseases are infections that affect the tissues and bone that support teeth. I have been informed that other factors can affect my periodontal disease and its progression, including the condition of my dental restoration, certain diseases (such as diabetes and heart disease), habits (tobacco use) and medications.

The factors that specifically affect me include: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The intended benefit of this treatment is to improve the health of my gums and teeth and try to retain my natural teeth as long as possible.

Other benefits may include: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The prognosis, or chance of success, of this treatment is:

- Good    Fair    Questionable    Poor    Hopeless

My treatment is estimated to take \_\_\_\_\_ visits to complete and is estimated to cost \$ \_\_\_\_\_ .

### ALTERNATIVE TREATMENTS

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative ways to treat my periodontal condition include:

- The following treatment:  
 No other reasonable treatment options exist for my condition.

I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including:

\_\_\_\_\_  
Patient's Initials

### RISKS OF THE PERIODONTAL TREATMENT

I understand that no dental treatment is completely risk-free and that my dentist would take reasonable steps to limit any complications of my treatment. I understand that some post-treatment effects and complications tend to occur with regularity. These include tooth sensitivity, pain from treatment, infection, swelling, dark spaces between teeth where there is no longer any gum tissue, changes in how long my teeth appear (due to recontouring) and the need to replace previous dental restorations due to changes in the position of my gums due to treatment. Other risks of my treatment include:

### RISKS OF NOT HAVING THE PERIODONTAL TREATMENT

I understand that complications to my teeth, mouth and/or general health may occur if I DO NOT proceed with the recommended treatment. These complications include:

- Additional Infection    Bleeding    Complication of Other Health Issues (Diabetes, Heart Disease, Stroke, Etc.)  
 Inability to Proceed with Other Dental Care    Mouth Odor    Pain    Swelling    Tooth Loss    Tooth Mobility  
 Other:

I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including:

\_\_\_\_\_  
Patient's Initials

**ACKNOWLEDGEMENT**

I, \_\_\_\_\_ have received information about the proposed periodontal treatment. I have discussed my treatment with Dr. Dillner and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of recommended treatment and my refusal of care.

I personally assume the risks and consequences of my refusal, and release from myself, my heirs, executors, administrators or personal representatives those dentists who have been consulted in my case from any and all liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

**I DO NOT wish to proceed with the recommended periodontal treatment.**

---

Patient or Guardian Signature	Date
Treating Dentist Signature	Date
Witness Signature	Date