James H. Tanner, DDS, MS, PA

Practice Limited to Periodontics

Authorization and Informed Consent To Periodontal Therapy

Patient:_____ Date:_____

This Authorization and Informed Consent to Periodontal Treatment is given to Dr. James H. Tanner (hereinafter "Doctor"). It is given of my own free will after Doctor has first explained to me the nature of the proposed treatment and /or surgical procedures involved and foreseeable dental and medical risks involved, as discussed below.

1. **Non-Treatment Risks**
   Doctor has advised me that if this condition persists without proposed treatment, the risk to my (or other name) dental health include, but is not limited to, the following:
   Further deepening of periodontal pockets; loosening of teeth; mouth odor; gum recession; abscesses(gum boils); tooth drifting, flaring or other tooth movement; and premature loss of teeth.
2. **Procedure**
   I hereby authorize Dr. Tanner and whomever he may designate as his assistant(s), to perform the following therapy: (recommended treatments are circled)
   a) **Local Anesthesia (with exception of _____)**
   b) **Scaling and Root Planing**
   c) **Periodontal surgery: gum grafts, flap surgery, bone graft, crown lengthening, implants, gingivectomy, biopsy, frenectomy, and circumferential fiberotomy.**
   d) **Extraction of teeth or root tips**
   e) **Nitrous Oxide and/or Oral sedation**
3. **Treatment Risks**
   Doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure and that in this specific instance such post-operative risks include, but are not limited to the following: *Swelling; discomfort; bleeding; thermal sensitivity; gum recession; infection; tooth mobility; spaces between teeth; numbness; loss of teeth or implants; and temporary restricted mouth opening.*
4. **Consent for Unforeseen Conditions**
   Doctor has explained to me that after commencing the proposed treatment plan and/or procedure, he may discover unknown conditions that good surgical procedure dictates should be remedied and attended to at that time. I therefore consent to the performance of such additional or alternative procedures as may be indicated by good surgical care.
5. **Pre-And Post-Operative Instructions (Circle if not applicable)**
   Because of the nature of the proposed treatment, certain prescribed medications may cause drowsiness, alone or in combination with alcohol or other sedatives. I have been advised not to drive or operate dangerous machinery within 24 hours of taking such medication. Accordingly, I have arranged to be driven and accompanied home by another person.
6. **No Warranty**
   Doctor has explained to me that if the proposed treatment and /or procedure is successful, the results would hopefully be:
   Improved long term retention of teeth; decreased progression of my periodontal disease; Decreased recurrence of gum abscesses (boils).
   I understand, however, that because of the nature of the proposed treatment and the uniqueness of every case, one cannot predict the certainty of success. I understand and appreciate the fact, and hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment and/or procedure will be curative or successful to my complete satisfaction.

Signature of Patient or Legal Guardian_____

Date:_____ Witness:_____