Consent for Scaling and Root Planning

# Recommended Treatment

I hereby give consent to Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to perform Scaling and Root Planing procedure(s) on me or my dependent as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Recommended Treatment”) and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

# Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
but I wish to proceed with the Recommended Treatment described above.

# Risks and Complications

I understand that there are risks and complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These potential risks and complications, include, but are not limited to, the following:

1. Drug reactions and side effects.
2. Post-treatment bleeding, oozing, and infection.
3. Bruising and/or swelling, delayed healing, restricted mouth opening for several days or weeks.
4. Varying lengths and degrees of sensitivity.
5. Increased spacing between teeth due to removal of hard deposits.
6. Revealing of recessed gums.
7. Increased mobility of teeth.
8. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |
|  | Patient/Parent/Guardian |  |  |
| Relationship (if patient a minor): |  |
| Witness (signature): |  |

This document is a sample form provided by MedPro Group and should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc. and MedPro RRG Risk Retention Group. All insurance products are administered by MedPro Group and underwritten by these and other Berkshire Hathaway affiliates, including National Fire & Marine Insurance Company. Product availability is based upon business and regulatory approval and may differ among companies. Visit [medpro.com/affiliates](http://medpro.com/affiliates) for more information. ©2017 MedPro Group Inc. All rights reserved.