Auburn Periodontics and Implantology
925 East Main Street
Auburn, WA 98002
253.833.2790

CONSENT FOR PERIODONTAL TREATMENT

I understand that I will be receiving recommendations for appropriate periodontal treatment. If I have any questions about any recommended treatment, I can ask for an explanation at any time. This is my consent to the treatment deemed or advisable and to the use of local anesthesia.

I understand that occasionally there are complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek, or teeth. More rarely, but occasionally occurring, are changes in the occlusion; temporomandibular joint discomfort; injury to adjacent teeth or other tissues; referred pain in the ear, neck or head; vomiting, allergic reactions; bone fractures and delayed healing. Sinus complications, which may include a nasal antral fistula or opening into the sinus from the mouth, may rarely occur.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which could be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous devices or work while taking such medications and/or drugs or until fully recovered from the effects of the above.

I understand that there is no warranty or guarantee as to any result and/or cure.

_____ _____

Signature of Patient, Parent or Guardian Date