EASTMAN CRAIGHEAD

PERIODONTICS • IMPLANTS • LASER SURGERY

## CONSENT TO PERIODONTAL AND DENTAL IMPLANT TREATMENT

I hereby authorize Dr. Lindsay Eastman, Dr. Christie Craighead, Dr. Justin Craighead, Dr. Rachael Voigt and whomever they designate to perform upon _____ (patient name) the following procedure(s):

___ Local Anesthesia (Novocaine, Lidocaine, etc)
___ Conscious sedation (N2O / Halcion / IV Versed)
___ General sedation - Anesthesiologist (P.D.A.A. / M.S.C.)
___ Salivary diagnostics (Perio Path)
___ Scaling & root planning (non-surgical therapy)
___ Occlusal Equilibration (bite adjustment)
___ Periodontal Microsurgery (Osseous/Flap)
___ LANAP (laser periodontal surgery)
___ LAPIP / R-PIT (regenerative peri-implantitis therapy)
___ Muco-Gingival Surgery (tissue grafting/root coverage/pinhole)
___ Frenectomy (facial / lingual)
___ Gingivectomy / Distal Wedge _____
___ Crown Lengthening / Root Re-shaping _____
___ Tori/Buttressing bone removal: _____
___ Extraction of teeth #'s _____
___ Bone Grafting (socket / ridge augmentation)
___ Sinus Augmentation (vertical / lateral window) UR / UL
___ Implant Placement / uncovery _____
___ Sectioning Restorations _____
___ Biopsy (bone biopsy / tissue biopsy) _____
___ Plasma Rich Fibrin (PRF)
___ Other: _____

I have been informed that the purpose of the above-mentioned procedures is to treat my periodontal disease, extraction of teeth and / or surgical placement of dental implants. I further understand that if no treatment is rendered, my periodontal condition will probably worsen in time, which may result in premature tooth loss and/or compromise in overall health.

If any unforeseen condition should arise during the proposed procedures, calling for the Doctor's judgment or for procedures in addition to or different from those now contemplated, I authorize the Doctor to do what he/she may deem advisable.

I understand that the doctors have provided an optimal treatment plan. I recognize that each step I choose that is a departure from the ideal recommended treatment proposed will be a compromise to the outcome. I recognize that I am responsible for the compromise and any lasting effects of varying from the recommended ideal treatment plan.

I have been informed that **conventional tissue grafting will not cover my recession** (the exposed areas of my roots).

Smoking is significantly associated with poor healing in surgical procedures and implant failures.

It has been explained to me that the long-term success of treatment requires my cooperation in following post-operative instructions, performance of plaque control (home care) at least twice a day, periodic periodontal maintenance visits after the proposed treatment and necessary follow-up restorative care by my dentist.

Regardless of which procedure(s) are being performed, the administration of any medication and / or surgical procedure involves certain risks which include, but are not limited to:

- Bleeding / Bruising / Swelling / Pain
- Infection that may require further treatment
- Surgical failure (Tissue, bone, implant, etc)
- Gum shrinkage (recession)
- Exposure of the crown margins
- Tooth sensitivity (hot, cold or biting down)
- Food impaction between teeth
- Damage to adjacent teeth
- Damage to restorations (crowns, fillings, bridges)
- Interference with phonetics (speaking)
- Paresthesia (nerve damage) permanent /temporary
- Restricted mouth opening (TMJ/TMD issues)
- Osteonecrosis: Patients taking Bisphosphonates
- Increased tooth mobility or looseness

I certify that I have read fully and understand the above consent to periodontal and/or implant treatment recommended. I acknowledge that all risks, benefits, alternatives and complications to this treatment have been explained to me.

_____ _____ _____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE TEAM SIGNATURE DATE

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