

Sample Form: Discussion and Refusal of Periodontal (Gum) Treatment

Patient's Name _____ Date of Birth _____
Last First Initial

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 Treatment

It has been recommended that I have the following periodontal treatment (all that apply have been checked for me):

- Scaling and root planing Osseous (bone) surgery and recontouring Gingivectomy (recontouring)
 Periodontal bone graft Soft tissue graft Referral to a gum specialist (periodontist)
 Other: _____

Teeth or areas of each recommended treatment: _____

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

- Chronic generalized periodontitis Chronic localized periodontitis Gingivitis/gingival disease
 Aggressive generalized periodontitis Aggressive localized periodontitis Other (as specified)

Teeth or area that applies to each diagnosis: _____

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 restorations, certain diseases (such as diabetes and heart disease), habits (tobacco use), and medications.

Factors specifically affecting me include: _____

The intended benefit of this treatment is to improve the health of my gums and teeth and to try to retain my natural teeth as long as possible. Other benefits may include: _____

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

My treatment is estimated to take _____ visits to complete.

My treatment 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 dental condition include:

Patient: _____

No other reasonable treatment option exists for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have
Patient's Initials heard or thought about, including _____.

Risks of the Recommended 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 after-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 Recommended 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:

- Pain Bleeding Swelling Mouth odor Tooth mobility Tooth loss
- Additional infection Complication of other health issues (such as diabetes, heart disease, stroke)
- Inability to proceed with other dental care Other: _____

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or
Patient's Initials thought about.

Acknowledgment

I, _____, have received information about the proposed periodontal treatment. I have discussed my treatment with Dr. _____ 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 the recommended treatment, and my refusal of care.

[The following release is optional.] I personally assume the risks and consequences of my refusal, and release for 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.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness

This sample form is for illustrative purposes only. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.