660 Kenilworth Drive, Suite 103
Towson, Maryland 21204
(410) 821-8800

FELDMAN, FITZGERALD and CHOE, D.D.S., P.A.
FAX: (410) 823-5715

Sylvan Feldman, D.D.S., M.L.A.
Diplomate, American Board of Periodontology
Diplomate, American Society of Osseointegration
Periodontics
Prosthodonitcs
Implant Dentistry
Cosmetic Dentistry

Bryan P. Fitzgerald, D.D.S
Diplomate, American Board of Periodontology
Periodontics
Implant Periodontal Prosthesis
Implant Dentistry
Cosmetic Dentistry

Kyong S. Choe, D.D.S., M.S.
Diplomate, American Board of Periodontology
Periodontics
Implant Periodontal Prosthesis
Implant Dentistry
Cosmetic Dentistry

CONSENT TO PERIODONTAL TREATMENT

Date: _____

Patient Name: _____

I have been advised that my complete dental examination has revealed the following condition(s): and the following procedures have been recommended**:**

_____

_____

_____

My doctor has advised me that alternative treatment methods exist, including no treatment.

Non-treatment risks: If I elect not to have any treatment, I understand there are certain risks including, but not limited to: gum recession, bad breath, inability to perform adequate dental hygiene, tooth mobility, abscesses, infection, pain, poor chewing, tooth sensitivity, tooth movement, worsening of my gum condition, deeper pocketing, premature tooth loss with need for replacement.
I have elected to treat my condition by the proposed treatment, rather than any alternative therapies. {Please initial}_____

Treatment Risks:
If you have previously been treated with **Bisphosphonate drugs** you should know that there is significant risk of future complications**. Bisphosphonate** drugs appear to adversely affect the ability of bone to break down or remodel itself thereby reducing or eliminating its ordinary excellent healing capacity. This risk is increased after surgery, extractions, implant placement, or any invasive procedure. Osteonecrosis, a smoldering, long term destructive process in the jawbone that is difficult or impossible to eliminate. Despite all precautions, there may be delayed healing, osteonecrosis, loss of bony and soft tissue, jaw fracture, oral–cutaneous fistula or other significant complications. Treatment may be prolonged and difficult including hospitalization. The surgical site is always subject to breakdown and infection. Frequent check-ups are imperative.

I understand that there are risks associated with the proposed treatment including but not limited to: swelling, bleeding, pain, sensitivity, gum shrinkage with exposure of crown margins, cosmetic changes, speech changes, loss of taste, infections, abscesses, loss of teeth, prolonged numbness, tooth mobility, food impaction, root staining, restrictions in mouth opening (secondary to swelling or to stress on the jaw joints), tissue loss, continued or recurrent gum disease, implant loss, root canal therapy or TMJ .

CONSENT TO PERIODONTAL TREATMENT

I have not been given any guarantee or warranty of success for this treatment, and understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same, better or worse after treatment and that ongoing care may be necessary.

I understand that to aid in successful treatment and to lessen the dangers of complications, I must meet certain requirements: excellent oral hygiene, proper diet with restrictions on certain hard or chewy foods, strict adherence to instructions about using medications or the wearing of appliances and cooperation in keeping appointments. I have provided a complete and accurate statement of my medical and social history. I have had full opportunity to ask questions about the information on this form and have been given answers that are to my satisfaction.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND MY SIGNATURE BELOW SIGNIFIES BY ACKNOWLEDGMENT THAT I BELIEVE I HAVE RECEIVED SUFFICIENT INFORMATION TO PROCEED WITH THE RECOMMENDED TREATMENT. ALL BLANKS WERE FILLED IN PRIOR TO MY SIGNING.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date