

INFORMATIONAL INFORMED CONSENT

INFORMED REFUSAL: PERIODONTAL SCALING AND ROOT PLANING (D4341/D4342)

I, _____, am aware of the gum infection and periodontal disease present in my mouth. I hereby release from liability Dr. _____, and his/her hygienists, employees and agents from any injury I may currently, or in the future, suffer as a result of my refusal to proceed with periodontal treatment or referral as recommended.

The recommended treatment plan, alternative treatments, and the benefits and risks involved have been fully explained to me to my satisfaction, and I have had all my questions answered. Inadequate or non-treatment may result in the progression of my gum infection and periodontal disease with the possible loss of gum tissue, bone, and teeth. My gum infection and periodontal disease may have adverse effects on my total body health. I fully understand these consequences and am willing to assume all of the risks involved. /

I have carefully read the above and understand this refusal for treatment.

Patient signature _____ Date _____

Witness signature _____ Date _____

