



# IMPRESSIONS DENTAL

5970 S. COOPER RD. STE #1 CHANDLER, AZ 85249 • (480) 814-8888

## Dental Treatment Consent Form

### Scaling & Root Planning Due to Periodontal Disease

I have been informed by either my dentist or dental hygienist that I have periodontal disease. I am aware that this means I have an active infection in my gum tissue causing bone loss. The treatment of scaling and root planing has been recommended to remove bacteria and slow the progress of periodontal disease. I understand that there is not a cure for this condition and additional scaling and root planing and/or periodontal surgeries may be necessary in the future. I understand that in most cases analgesics are required to numb the area being worked on; analgesics can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have also been informed that I need to return for more frequent cleanings in order to maintain the results achieved with scaling and root planing; this may be every 3 or 4 months and may not be covered by my dental insurance provider.

Patient Name: \_\_\_\_\_

Patient and/or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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