Tuan M. Nhu, DDS

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GERMANTOWN
DENTAL VILLAGE

CONSENT FOR ROOT PLANING

I hereby authorize Dr. Tuan Nhu or his dental hygienist to perform scaling and root planing on my gums. I also understand that Dr. Nhu is not a gum specialist (periodontist), and I am declining immediate referral to a specialist at this time. I further understand that Dr. Nhu may cease treatment and make a referral to a specialist should any unanticipated difficulty or untoward event occur during or after treatment at my additional expense.

I have been informed of the need to have scaling and root planing, and the details of the procedure have been explained to me, and I fully understand them.

I understand that gum disease is site specific and episodic, meaning that it occurs at different places in my mouth during different times of my life. I further understand that gum disease treatment is more costly than "a cleaning" and that scaling and root planing may need to be repeated several times during my life, or gum surgery may be needed, at additional expense to me. I understand that the success or failure of gum disease therapy is dependent on many factors like, but not limited to, my home dental hygiene habits, my body's response to disease, my genetic predisposition to gum disease, my maintaining regular and timely professional maintenance recall visits on the schedule prescribed by my dentist, and my overall health.

I understand that following the completion of root planing there may be a period of discomfort accompanied by some bleeding, swelling and pain.

I have been made aware that smoking will jeopardize the healing process and anticipated outcome of therapy.

If I am taking any anticoagulant medication such as warfarin (Coumadin), aspirin, or any blood-thinning supplements, I have informed Dr. Nhu, and acknowledge that we have discussed the risks of prolonged bleeding times. I understand that if bleeding does not stop in a reasonable time period that I will need to seek care at the nearest Emergency Room at my own expense.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the procedure, I agree to report them to Dr. Nhu as soon as possible. I have been told that the success of the surgery depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained. I further understand that gum disease or loss of attachment is a chronic condition which may progress or worsen with or without surgery.

I have discussed all of the above with the doctor, and have had all my questions answered.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Witness: _____ Date: _____