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Grant T. King, D.D.S, M.D.S.*
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*Board Certified Periodontist and Dental Implant Surgeon

Periodontal Associates
OF MEMPHIS
Periodontal, Laser and Dental Implant Therapy

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CONSENT FOR NONSURGICAL PERIODONTAL TREATMENT (SCALING AND ROOT PLANING)

I _____ (name of patient) hereby authorize Drs. Godat, King, Byakina and Team to perform non-surgical periodontal scaling and root planing. I have been informed that the purpose of this procedure is to treat and possibly correct my diseased gum tissues, teeth, implant, and/or supporting jawbones.

I have been informed of other possible alternative and/or supplemental methods of treatment, if any. Post-operative risks of the proposed treatment include, but are not limited to: pain, parasthesia (numbness) from anesthetic injections which may persist for several weeks or in rare instances permanently; gum recession (shrinkage); clicking, limited opening, or pain of the temporomandibular joints (TMJ)(jaw joints); tooth sensitivity to hot or cold, tooth mobility (looseness); food lodging between the teeth after meals which may require special cleaning devices; and exposure of crown margins of teeth in the treatment areas.

I further understand that if no treatment is rendered, my present periodontal condition will probably worsen in time, which may result in premature tooth and/or implant loss.

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the best of care. However, it is Drs. Craddock's, Godat's, King'sx and/ or Teams opinion that therapy will be helpful, and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment.

I understand that success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic periodontal maintenance (cleaning) visits (recall professional care).

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent and the explanation referred to or made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed. I also state I read and write English. I consent to photographs of my oral and facial structures and their publication for educational and scientific purposes.

Dentist Signature	Patient Signature / Date
Witness Signature / Date	Parent or Guardian, if Patient is a Minor / Date

All Consent forms should be signed and returned or faxed to our office 3-5 days before surgery. Fax: 1.901.761.3775 **Last updated 8.8.24**