 REQUEST AND CONSENT FOR PERIODONTAL/ORAL/IMPLANT SURGERY

PATIENT CONSENT: THE ATTENDING DENTIST IS RESPONSIBLE FOR OBTAINING CONSENT AND FOR CROSSING OUT ANYTHING THAT DOES NOT APPLY OR TO WHICH THE PATIENT DOES NOT CONSENT

I request and authorize Paul C. Kazmer, Jr., DMD, MS and assistants of his choice, to perform the following treatment/procedure(s) for:

Name of Patient:_____

Description of Treatment/Procedure(s):_____

_____

Description of Patient's Condition/Problem(s) Being Treated:_____

_____

1. I further request and authorize the taking of oral-dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable, to diagnose and/or treat my/the patient's dental problem(s).

2. I have had explained to me, and I have had sufficient opportunity to discuss my/the patient's dental condition, the treatment procedure(s), and the benefits to be reasonably expected from this treatment, compared to alternative approaches and/or no treatment. Specifically, I understand that periodontal surgery is intended to correct anatomic deficiencies, arrest further progression of the disease process, and generally to save a tooth/teeth that might otherwise be lost.

3. I have been informed that the potential for long-term success of treatment requires my cooperation including daily oral hygiene habits such as tooth brushing and flossing to control plaque, as well as regular periodic recall visits upon completion of the proposed treatment/procedure(s). I understand that there is always a risk of treatment failure, relapse, or worsening of my/the patient's periodontal condition despite treatment. I also understand that if no treatment is rendered, my/the patient's periodontal condition may worsen in time and result in the loss of teeth. I acknowledge that no guarantees have been given to me regarding the results of treatment, or whether it will be curative and/or successful to my complete satisfaction.

4. I understand that smoking is hazardous to my health and hinders/alters the healing process, making the results of periodontal therapy, surgery and dental implant surgery less predictable.

5. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during and following treatment, bruising, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, temporary or permanent numbness, and allergic reactions. Treatment complications may require treatment by another dentist, oral surgeon, physician, nurse or other health care provider. I understand that I will be responsible for any fees incurred, if treatment by another health care provider is necessary. During treatment, complications or unexpected situations may be discovered which may make tooth/root extraction, and/or bone grafting, and/or other treatment(s) necessary.

6. I have been advised that some prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, either alone or in combination with alcohol, tranquilizers, sedatives, or other drugs. Because of this possibility, I understand that it is not advisable to operate any vehicle, automobile, or hazardous device until fully recovered from their effects.

Initialize Please:____ Then turn over and continue___

7. WOMEN ONLY: If on birth control pills, it is IMPORTANT TO UNDERSTAND that ANTIBIOTICS have been reported to decrease oral contraceptive effectiveness, resulting in a CHANCE OF UNPLANNED PREGNANCY. If antibiotics are prescribed, other contraceptive methods are recommended if pregnancy must be avoided.

8. I authorize Dr. Paul C. Kazmer Jr., and staff to examine and dispose of any tissues which may be removed. I understand that it is my responsibility to seek care with a restorative dentist who will diagnose and treat restorative and/or other dental treatment needs. My treatment with Paul C. Kazmer, Jr., DMD, MS, PA is limited to periodontal and/or dental implant concerns.

9. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for me/the patient.

10. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

11. I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

SIGNATURE OF PERSON CONSENTING TO TREATMENT:_____

DATE:_____ TIME: _____ PRINT NAME:_____

RELATIONSHIP TO THE PATIENT (if not self):_____

CONSENT CERTIFICATION

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the treatment and procedures specified above. I have offered to answer any questions and have fully answered such questions. I believe the patient/relative/guardian understands what I have explained, and has consented to the proposed treatment and procedures.

SIGNATURE OF DENTIST:_____ DATE:_____ TIME:_____

WITNESS CERTIFICATION

I hereby certify that the patient/relative/guardian either: has acknowledged in my presence that he/she has received an explanation of, and alternatives to, the proposed dental treatment/procedures, usual and most frequent risks and hazards of, and alternatives to the proposed treatment/procedures, has had all of his/her questions answered, has given his/her consent, and has signed this form where indicated; or after the informed consent discussion and signatures above, has answered "yes" to all of the following questions:

1. Did the doctor explain the treatment and procedure(s) to you?
2. Have all your questions about the treatment and procedure(s) been answered?
3. Is this your signature on the consent form?
4. Have you given your consent to the proposed treatment and procedure(s)?

WITNESS SIGNATURE :_____ DATE:_____ TIME:_____

PRINT NAME: _____