

Consent for Laser Pocket Reduction Surgery

The Health Sciences continue to make remarkable advances in technology and techniques. These efforts to develop and introduce improvements over current health care treatments, are ultimately intended for the benefit of prospective patient candidates. An essential element in these efforts is to communicate all essential information to patient candidates, so that the prospective patient is able to make a knowledgeable decision. With this premise in mind, all of the pertinent facts involved in the cooperation between the surgeon, and the prospective patient is listed in detail below, so that there is a full disclosure of the procedures and complete comprehension by the patient. It is necessary that each patient read, understand, and sign the following form before proceeding with the Laser Assisted New Attachment Procedure--Laser ANAP. LANAP is trade mark for a full mouth and I may not need all teeth treated, therefore, I am not technically having LANAP although the procedure and science is the same the trademark only applies to a full mouth.

- I. I have consulted my doctor because I seek a solution to my dental problem by using the laser to treat the gum disease that has been diagnosed as needing Laser periodontal surgery.
- II. I acknowledge that my doctor has carefully examined my mouth. In the doctor's opinion, dental Subgingival excision with a contact laser fiber may help the problems from which I have been suffering.
- III. I understand that in the doctor's experience, a large percentage of Laser cases (87%) have not needed retreatment for more than five years barring any unforeseen health or accident problems. There are limited long term studies of the partially edentulous situation. Laser seems to be more predictable than other types of dental gum surgery.
- IV. My doctor has explained other alternative periodontal surgical procedures such as traditional osseous/periodontal surgery, cut and sew and other methods. I hereby state that I have tried or considered conventional methods of periodontal surgery and regard them to be unsatisfactory for me.
- V. I acknowledge that my doctor has explained that optimum results with Laser depend on the individual body response of each person. There is no method in the present knowledge to guarantee the healing capabilities of any patient following treatment by Laser.
- VI. My doctor has stated that smoking and/or non-moderate use of alcohol can adversely affect gum tissue healing. Observation has shown that excesses in any of the above may limit the longevity and prognosis of the Laser treatment. It has been observed that smokers tend to heal half as well and relapse twice as often as non-smokers following any periodontal therapy. I understand that calcium balance and hormones can affect the continued loss of bone.
- VII. My doctor has detailed the methods and importance of oral hygiene. I agree to cooperate in order to accomplish my personal home care as instructed by my doctor or the doctor's staff. I further agree to follow my doctor's post treatment instructions and diet recommendations. I understand that this is critical for optimal healing.**

My doctor has explained that if nothing is done the following sequences of events can happen:

A. Where no treatment is undertaken, further gum and bone degeneration of the supporting tissues can continue, increasing the severity of, and/or adding to, the problems presently suffered by the patient to include:

1. Loss of teeth due to traumatic occlusion and/or loss of vertical bone support.
2. Infections in the gums and bone such as ANUG. (Acute Necrotizing Ulcerative Gingivitis)
3. Tarter/calculus buildup causing loss of vertical bone support which could lead to loss of teeth

B. Where groups of teeth are missing:

1. Non replacement of teeth -- in areas where excessive chewing forces exist -- may cause pronounced loss of bone, and gum disease around the remaining teeth.
2. Patient may replace teeth with conventional removable partial dentures.

My doctor has explained that it will be my responsibility to report to this office every three(3) months, or at any other recommended time to carefully check the status of my Laser treatment and for regular hygiene appointments. -

I. I submit that I have given an accurate report on my health history. To my best knowledge I have not withheld any information regarding my medical or mental health. Any previous allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollens, dust, or any material or condition have been willingly offered to the doctor for my complete health history.

II. I understand that Laser involves one or more mouth surgeries. I have been informed of the complications of the surgery, anesthesia, and necessary drugs which are used. I am aware that there could be pain, swelling, infections, discoloration, numbness, spaces between the teeth, tissue shrinkage, and recession of the gums, and exposure of roots surfaces-- the exact extent and duration which may not be determinable. I understand that after adequate healing some areas may need to be spot treated with Laser and occlusal adjustments.

III. I understand that "severe" gum disease (Case Type III & IV) with "double digit" millimeter pocket measurements (e.g. 10mm or more) will require "double" or a subsequent re-treatment at the same fee as the first fee-for-service, typically on a tooth-by-tooth basis, but could involve the entire mouth as determined by the state of active disease.

IV. "Occlusal adjustment" and "occlusal equilibration" has been fully explained to me. I have had the opportunity to ask questions, and I fully understand that occlusal adjustments and equilibration require my 100% cooperation and compliance. It has been explained to me that failure to complete all phases of occlusal adjustments and equilibration may result in oral-facial pain, temporal mandibular joint dysfunction (TMJ) sore and painful teeth; and that it has been explained to me that until the teeth have been fully adjusted and/or equilibrated I may experience transitional TMJ pain, muscle soreness, headaches, tooth pain, tooth sensitivity, and cheek biting. I understand adjusting crowns can remove porcelain, expose metal and/or tooth structure, and may require the replacement of any and all crowns. I understand that occlusal adjustment is part of Laser and is an ongoing part of my regular examination appointments.

V. I am further advised that I may receive an explanation of all risks and treatment(s) prior to starting, as well as any other questions during the progress of my treatment, just by asking my doctor.

VI. If my doctor considers my case appropriate, I hereby give authorization for photos to be taken of my mouth during the course of Laser ANAP treatment. It has been explained that these photos, slides, or X-rays may be used in teaching other dentists for the advancement of Laser in dentistry.

VII. With full understanding, I authorize my doctor and the Laser team to perform dental services for me, including Laser and other surgery deemed necessary for the planned treatment. I will also agree to the use of local or general anesthetic, sedation, and analgesia depending on the judgment of the surgeon involved in my case. My doctor has explained that if there is a need for someone to drive me from the doctor's office following surgery I am to arrange this

myself. I agree not to operate a motor vehicle or work for 24 hours or until fully recovered from the effects of the anesthesia or drug given me for my care, if it should be necessary.

VIII. I understand that my doctor will do the very best according to all of the latest principles of Laser dentistry to perform Laser. Because of continuing progress in Laser dentistry I authorize any modifications in designs, materials, or care – if, based on experience and professional judgment, the doctor feels it is for my best interest.

IX. I understand my first follow up after laser therapy (typically 1-2 weeks after) will include a cleaning of the areas treated. There is no charge for this post-op exam or cleaning. If an occlusal adjustment is needed, there will be a charge for that adjustment. All cleanings after the initial 1-2 week cleaning are charged out and the exam one year later will also have an exam fee. I understand that is necessary to complete all phases of recommended treatment, and agree to do so.

Patient's (or Legal Guardian's) Signature

Date

Witness' Signature

Date