Consent Form for Periodontal Disease Treatment

Dental Hospital

Name: ..... Age: ..... HN: .....

have decided to undergo treatment for periodontal disease. I have been informed of the treatment plan and the following details:

1. Facts for Consideration

Periodontal disease is a condition affecting the tissues and structures around the teeth, including the gums, periodontal ligament, cementum, and alveolar bone. In the early stages, the disease may present no symptoms. However, as it progresses, these structures deteriorate, leading to bone loss, gum recession, swelling, pain, tooth mobility, and, ultimately, tooth loss. This condition is commonly referred to as **"Periodontitis"**

The treatment of periodontal disease focuses on eliminating bacteria that cause the disease and removing bacterial habitats. **Initial treatment** involves scaling and root planing, both above and below the gumline, along with oral hygiene instruction to aid the body's natural healing process. After approximately **4-6 weeks**, a follow-up appointment is scheduled to assess healing. If deep periodontal pockets persist, **periodontal surgery** may be necessary.

2. Benefits of Treatment

The treatment of periodontal disease helps:

- ☐ Reduce infection and inflammation in the periodontal tissues
- ☐ Repair the gums and alveolar bone, improving overall oral health
- ☐ Extend the lifespan of teeth

3. Risks and Possible Complications of the Procedure

- ☐ Possible **bleeding** after scaling and root planing
- ☐ **Mild gum pain** for about **1-3 days** after treatment
- ☐ **Gum recession**, making it feel like the gums have receded further
- ☐ **Tooth sensitivity** to hot and cold temperatures, which typically improves within **1 month**

4. Treatment Alternatives

- ☐ **No treatment**, which may lead to disease progression
- ☐ **Tooth extraction** for severely affected teeth

5. Consequences of No Treatment

If untreated, the disease may **progress further**, causing gum swelling, tooth mobility, and eventually leading to **tooth loss**.

6. Treatment Costs

Treatment costs are based on the **fee schedule and service charges** of the **Faculty of Dentistry, Prince of Songkla University**, as per the latest updated rates.

7. Patient Decision

☐ I have discussed the treatment options and costs with my dentist.

☐ I have received satisfactory answers to my questions regarding the procedure, risks, benefits, and costs.

I choose the following option:

☐ I **consent** to periodontal disease treatment and accept the associated risks, benefits, and costs as stated. I also consent to necessary dental X-rays throughout the treatment.

☐ I **do not consent** to periodontal disease treatment. I acknowledge that I have received information and accept the potential consequences of not receiving treatment.

Signature: ..... Signature: .....

(.....) (.....)

Treating Dentist Patient / Authorized Representative

Relationship to the patient: .....

Signature: ..... Signature: .....

(.....) (.....)

Witness Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.