Don D. Franklin, D.D.S. Periodontics

1408 Orchard Lake Drive
Charlotte, NC 28270

Request and Consent for Periodontal Surgery

1. I request and authorize Dr. Don D. Franklin and/or his associates or assistants 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: _____

   _____

2. 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).

3. 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.

4. 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 there is always a risk of treatment failure, relapse, or worsening of my/the patients 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.

5. The usual and most frequent risks or complications occurring from the planned treatment and procedure(s) 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. During treatment, complications may be discovered which may make tooth/root extraction necessary.

6. I have been advised that the 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, of hazardous device until fully recovered from their effects.

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

9. 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.

10. I confirm that I have read and understand this form, or that 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: _____

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 procedures.

SIGNATURE OF THE DENTIST: _____ DATE: _____