Authorization for Periodontal Therapy Flap Osseous Surgery using Nd:YAG Laser

I _____ fully understand the following:

1. I have been referred to Dr. Pearl Lai for treatment for my periodontal condition. This disease has resulted in the loss of bone and attached gingiva that normally supports teeth.
2. I have been informed of traditional methods of periodontal therapy including surgical intervention with associated risks of receded gums and hot and cold sensitivity. I acknowledge Dr. Pearl Lai has explained the optimum results with laser depends 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. The expected results and risks of the proposed treatment (and/or no treatment) have been explained to me.
3. I understand there is no guarantee of success or permanence of the treatment and that dental conditions in my mouth can change and alter the proposed treatment plan. Individual results vary depending on several factors some which are beyond my control or my doctors. I understand compliance such as receiving regular dental care, home hygiene practice, and diet contribute to my outcomes. If I am a tobacco user, I understand my success rates lower significantly.
4. I understand that any time my teeth or soft tissue are manipulated, whether by traditional dental technology or laser dentistry, there is always a possibility of risk of unexpected and undesirable side effects, which may include oral-facial pain, swelling, tooth sensitivity, infection, and loss of teeth.
5. There is no method that will accurately predict or evaluate how gum and bone will heal. The success of bone regeneration procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, and medications.
6. Occlusal adjustments and occlusal equilibration" have been fully explained to me; this is often referred to as a bite check and adjustment. I have had the opportunity to ask questions, and I fully understand that occlusal adjustments and equilibration require my 100% cooperation and compliance. I further understand that the final healing has occurred, I may experience transitory TMJ pain, muscle soreness, headaches, tooth sensitivity, cheek biting. I understand adjusting crowns can remove porcelain, expose metal and/or tooth structure, and requiring the replacement of any and all crowns.
7. Dr. Pearl Lai has explained that it will be my responsibility to report to the office every three months for a regular hygiene appointment. I understand that these follow-up examinations are separate from surgery fees. I understand that it is necessary to complete all phases of recommended treatment and agree to do so.
8. With full understanding, I authorize Dr. Pearl Lai to perform dental services for me, including periodontal surgery using the Nd:YAG 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 judgement of Dr. Pearl Lai.

_____	_____	_____
Patient's Signature	Date	Patient's Name
_____	_____	_____
Signature of Patient's Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	