Declaration of consent "Periodontal Therapy"

Patient data

University Hospital Tübingen

Dept. of Conservative Dentistry
Osianderstrasse 2-8
72076 Tübingen
Germany

Findings/Diagnosis: _____

Planned therapy: periodontal therapy on teeth _____ ☐ maxilla ☐ mandible

Treatment alternatives

☐ tooth extraction and subsequent prosthetic restorations (e.g.clasp denture, complete denture)

☐ other: _____ ☐ none

Possible side effects and complications of the planned treatment

bleeding, circulatory complaints, allergy, nerve injury ■ injury to dental hard substance and surrounding tissue ■ postoperative pain from wounds, swelling, inflammations with accumulation of pus ■ continuing inflammation with possible further tooth loss, receding gums, sensitive cervical root areas, increased risk of root surface caries, instrument fracture, fever, wound infection, haematoma

☐ in your case, the following risks exist in particular: _____

Course, behavior of the patient before, during and after treatment, aftercare

do not smoke ■ no participation in road traffic, no alcohol or coffee ■ removal of sutures/wound dressing plates ■ regular oral hygiene and dental check up appointments including professional tooth cleaning ■ do not clean the surgical area for _____ days after surgery ■ recall appointments permanently necessary for proper care

☐ other information: _____

Neglecting treatment/possible alternatives – possible adverse consequences

further bone resorption and tooth loss, bad breath, gingival bleeding, complaints ■ simplest prosthetic restorations ■ deteriorating initial situation for later implantation due to bone resorption ■ periodontal abscesses ■ effects on the entire organism

☐ other possible adverse effects in the present case: _____

Costs according to additional cost agreement (was given to me)

Unforeseeable developments may result in additional costs.

Confirmation about having been informed

My dentist discussed all points in detail with me. I understood everything and have no more questions. I considered my decision thoroughly and do not need any more time for reflection.

☐ received information on periodontal therapy (→ Form "Dental Treatment").

Declaring participation in supportive periodontal therapy in the form of periodontal aftercare

☐ I was informed in detail by my dentist that consistent risk-related aftercare (3, 6 or 12 months) is necessary for the lasting success of the periodontal therapy I received.

☐ I was also informed that consequent aftercare can be provided by my family dentist or the Department of Conservative Dentistry

☐ I agree to participate in a periodontal aftercare program.

Patient consent

☐ I agree to the proposed treatment/s. This is also valid for possibly needing anaesthesia, about which I was informed separately, as well as for necessary changes/additions/additional or follow-up treatments. I can withdraw my consent until the start of treatment.

☐ I **do not** agree to the proposed measure(s)/treatment(s) and confirm herewith that I have been informed about the possible consequences of not doing so.

☐ I did receive a copy of this consent.

☐ I **do not** wish to accept the copy of the consent offered to me.

Signature of the dentist	Signature of the assistant
Place/date	Signature of the patient/legal representative/caretaker/ authorized representative*

* Where the consent of parents for their child is concerned: In principle, the consent of both parents must be obtained. If one parent signs without the other parent's signature, he or she also declares that he or she has the sole custody or that the other parent has authorized him or her to make the declaration on his or her behalf.