PERIODONTAL PATIENT INFORMATION AND CONSENT

I hereby authorize Dr. Douglas F. Dompkowski, D.D.S., hereinafter called "Doctor," to perform periodontal treatment, including examinations, radiographs, scaling, prophylaxis and periodontal surgery.

I have been informed of the possible risks and complications involved with the periodontal treatment, drugs and anesthesia. Post-operative risks of the proposed treatment include, but are not limited to: swelling; infection; pain, discoloration; restricted mouth opening for several days, weeks or longer; numbness of the lip, tongue, chin, cheek or teeth may occur for several weeks, months, or in remote cases, permanently; gum recession (shrinkage); tooth sensitivity to heat or cold for days, weeks or, on occasion, several months; exposure of crown margins; tooth mobility or looseness in certain areas; inflammation of a vein; injury to adjacent teeth; bone fractures; sinus penetration; delayed healing and allergic reactions to drugs and medications used.

I agree to the type of anesthesia, depending upon the choice of the doctor. To my knowledge, I have given accurate report of my physical and mental health history. I have also reported any prior allergies or unusual reactions to food, drugs, insect bites, anesthetics, pollens, dust, blood or body disease, gum or skin reaction, abnormal bleeding or any other condition related to my health.

I fully understand that during and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, materials or care, if it is felt this is in my best interest. In the event that extraction of any teeth is deemed advisable by the doctor due to the conditions visualized and determined at the time of surgery, I hereby consent to all such extractions.

No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment or worsening of my present condition, despite the best of care. However, it is the doctor's opinion that therapy will be helpful and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment.

I understand that if nothing is done any of the following could occur: bone disease; loss of bone; gum tissue inflammation; sensitivity; looseness of teeth, followed by necessity of extraction.

I understand that long-term success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic periodontal maintenance visits (recall professional care).

I consent to photographs (Kodachromes) of my oral and facial structures and their publication for educational and scientific purposes.

I impose no specific limitations, constraints or prohibitions regarding this treatment, other than:

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_____ _____

Patient Signature (if patient unable to sign, or is Minor-signature of parent/legal guardian) Date

_____ _____

Douglas F. Dompkowski, D.D.S. Date

_____ _____

Witness (note relationship to patient-if any) Date