INFORMED CONSENT: Cleaning and Scaling

Patient's Name: _____ **Date:** _____

Dentist's Name: Barbara Galera, D.D.S.

Benefits and alternative treatments

Prevent gum disease
Eliminate mouth odors
Cleaner looking teeth
Some portions may be performed by an auxiliary personnel
Alternatives: None

Common Risks

Sensitive teeth
Feelings of spaces between teeth
Fillings may be loosened (normal if filling was ready to fall out)
Sensitive gums

Consequences of not performing treatment

Gum disease
Will lose teeth sooner
Tooth decay
Staining on teeth

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

☐ I give my consent for the proposed treatment as described above.

☐ I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision to refuse treatment.

_____
Patient's Signature Date

_____
Dentist's Signature Date

_____
Witness's Signature Date