ETOBICOKE PERIODONTICS

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INFORMED CONSENT FOR DEEP SCALING
(Root Surface Planning)

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Specialist in Periodontics

PLEASE ASK IF YOU HAVE ANY QUESTIONS BEFORE SIGNING THIS DOCUMENT

Root planning is the thorough cleaning and smoothing of the root surfaces. For patients with periodontal disease, root planning usually involves cleaning the root surfaces beneath the level of the gum. If your teeth or gums are sensitive, then root planning is performed under local anesthetic. After root planning is performed, the gum tissue around your roots and teeth will begin to heal. For proper healing to occur, it is very important that you keep your teeth and gums very clean during this healing phase. You will be instructed with the proper methods of cleaning your teeth and gums.

After root planning, you may notice the following:

- Temporary sensitivity to brushing, temperature (hot/cold), and certain foods
- Minor gum bleeding during brushing or flossing (typically 10–14 days)
- Gums appearing to "shrink" as they become healthier
- More visible spaces between teeth or crown margins
- Temporary tenderness when chewing

If sensitivity becomes severe or persistent, please contact the office — desensitizing treatments are available. Teeth with advanced bone loss may be at greater risk for requiring root canal treatment in the future.

PATIENT'S RESPONSIBILITIES

I understand that my participation is important for success in this treatment. I agree to:

- Provide accurate medical and dental history
- Take all medications as prescribed
- Maintain proper oral hygiene as instructed
- Avoid tobacco and minimize alcohol use
- Attend scheduled and follow-up appointments
- Contact the office if complications arise

Failure to comply may result in delayed healing or reduced treatment success.

PATIENT CONSENT

I have been fully informed of the surgery to be performed and details of the post-op instruction provided well in advance of the surgery. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self-care. I realize that during the surgery, the treatment may need to be modified due to existing conditions that are only evident when the surgical site has been exposed.

I, _____ ACKNOWLEDGE THAT THE ABOVE HAS BEEN EXPLAINED TO MY SATISFACTION INCLUDING POST-OP INSTRUCTION THAT MY QUESTIONS HAVE BEEN ANSWERED, AND THAT I UNDERSTAND THE RISKS AND SO I HEREBY CONSENT TO THE PROCEDURES DESCRIBED WITH THE FEE ESTIMATE

DATE: _____

PATIENT NAME: _____

SIGNATURE: _____

I confirm that I have reviewed the above information with this patient and believe they understand the proposed treatment, risks, and alternatives.

Dr. Jae Chang Signature: _____