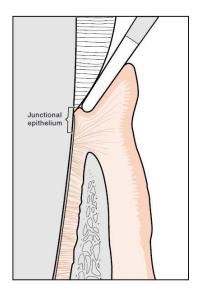


ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTICS

3rd YEAR

LOGBOOK



DEPARTMENT OF PERIODONTOLOGY LOG BOOK

Head of Department	Reviewed & Approved By: DME, AIDM

CERTIFICATE

This is to certify that,	
Mr./Miss.	
has completed his / her clinical rotation in the depar	tment of Periodontics from
to	His / Her clinical performance was
Satisfactory / Unsatisfactory during this period.	
The overall grading is	

Head / Incharge of the Department

PROTOCOLS FOR PERIODONTOLOGY DEPARTMENT

- OPD timings should be strictly followed i.e. 8:30 to 11:00
- Students need to carry their logbooks with them everyday during the rotation and get them signed timely by the assigned supervisors.
- O Late work will not be signed.
- OPD territory. Students are self-responsible for their belongings (Instrument, Materials, Books, Mobile & Money etc) in the
- Students' performance will be evaluated throughout the rotation and final assessment will be done at the end of rotation.
- Students should be punctual and regular in the department.
- Leave without prior information will not be accepted. Strict action will be taken.

REQUIREMENT FOR CLINICAL ROTATION

BY THE END OF THE CLINICAL ROTATION STUDENT MUST HAVE SHOWN

- 17 Cases of History taking, Informed consent, Cross infection practices (PPE), Intra-oral examination & extra-oral examination and Basic Periodontal Examination.
- **04** Cases of Diagnosis of periodontal disease, with perio-probing and charting and treatment by manual and power driven instruments for supra and subgingival periodontal disease
- **16** Cases of Supra and subgingival root surface debridement in pocket depth of less than 5mm and absence of furcation defects.
- 12 Assessments of patient radiographs.
- 03 Cases of Periodontal emergencies.
- **04** Cases of comprehensive treatment plan.
- **18** Prescription writings.
- 16 Cases of Non-surgical periodontal therapy (manual and ultrasonic scaling).
- 03 Cases of Non-surgical periodontal therapy (Root surface debridement).
- **Observing 02** Cases of crown lengthening surgery involving not more than 2 teeth and/or aesthetic zone.



ALTAMASH INSTITUTE OF DENTAL MEDICINE

History & Clinical Examination

Date:	Reg No			
Personal Information				
Name:	Sex:	Age:	Marital Status:	
Address:				
Contact No:	(Occupation: _		
Chief Complain:				
History of Complain:				

Medical History:

1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis
7.	Bleeding Disorder:
8.	Kidney:
9.	Drug Allergies:
10.	Viral / Immune Disorders:
11.	Any previous Operations / Surgical Procedures:
12.	Drugs for any Disease:

Females Only:	
Pregnant: Y N	
If Yes, Which Trimester: 1 2 3	
Family History:	
<u>Dental History:</u>	Y N
1. Past Dental Treatment	
2. Bleeding while brushing/Flossing	
3. Sensitive teeth	
4. H/O Periodontal Surgery	
5. Wore Braces	
6. Halitosis	
Oral Hygiene Methods	
Methods of Brushing:	
Toothbrush type:Paste/Powder:_	Inter-proximal Cleaning:
Habits (Dental)	
 Smoking Pan/ Betel nut Chewing /Others 	
Tany beta nat eneming / others	
3. Bruxism	

4.	Mouth Breathing/ any other	
•		
Soft T	<u>issue</u>	
1.	Skin/Face	
2.	Cheeks	
3.	Frenum	
4.	Palate	
5.	Lips	
6.	Floor of Mouth	
7.	Tongue	
<u>. </u>		
<u>Occlu</u>	sion:	
<u>Gingiv</u>	<u>ra:</u>	
1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
												·				Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings	
Diagnosis	
Differential Diagnosis	
Treatment Planning	
(a) Evaluation of the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) Root Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication	

Date	Treatment	Initials

Follow Up:

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include periodontal scaling and root planing. This includes the nonsurgical scraping of tooth roots and lining of the gum, with or without medication, in an attempt to further reduce bacteria and calculus (tartar) under the gumline - with the expectation that this may not fully eliminate deep bacteria and calculus, and may not substantially reduce gum pockets. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment - with the expectation of possible advancement of my condition which may result in premature loss of teeth; (2) extraction of teeth involved with periodontal disease; and (3) periodontal surgery without prior scaling and root planing, this alternative is sometimes recommended depending upon the nature of the disease found in a specific patient.

Necessary Follow-up Care and Self-Care. I will need to come for reevaluation appointments following my periodontal scaling and root planing so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of this treatment and determine if further therapy is needed. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment since my periodontal treatment will probably not be successful without proper periodontal maintenance in the years to come.

No Warranty Or Guarantee. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help me, keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

I have been fully informed of the nature of periodontal scaling and root planing, the risks and benefits and of the possible need for periodontal surgery, the alternative treatments available, and the necessity for follow-up and selfcare. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of periodontal scaling and root planing as presented to me during consultation and in the treatment plan presentation as described in this document.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date
Parent, or Guardian)	
(Printed Name of Witness)	Date
(Dental Surgeon)	Date

ALTAMASH INSTITUTE OF DENTAL MEDICINE

History & Clinical Examination

Date	e: Reg No
<u>Pers</u>	sonal Information
Nam	ne:Marital Status:
Addı	ress:
Cont	tact No:Occupation:
Histo	ef Complain:ory of Complain:
Medica 1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
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2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:	
8.	Kidney:	
9.	Drug Allergies:	
10.	Viral / Immune Disorders:	
11.	Any previous Operations / Surgical Procedures:	
12.	Drugs for any Disease:	
Females	s Only:	
_	nant: Y N s, Which Trimester: 1 2 3	
Famil	ly History:	
	Y N	
Dental H		

De

- 1. Past Dental Treatment
- 2. Bleeding while brushing/Flossing

	4. H/O Periodontal Surgery	
	5. Wore Braces	
	6. Halitosis	
Oral Hy	ygiene Methods	
Method	ds of Brushing:	
Toothb	rush type:Paste/Powder:	Inter-proximal Cleaning:
<u>Habits</u>	(Dental)	
1.	Smoking	
2.	Pan/ Betel nut Chewing /Others	
3.	Bruxism	
4.	Mouth Breathing/ any other	
•		

3. Sensitive teeth

Soft Tiss	<u>ue</u>		
1.	Skin/Face		
2.	Cheeks		
3.	Frenum		
4.	Palate		
5.	Lips		
6.	Floor of Mouth		
7.	Tongue		
<u> </u>			
<u>Occlus</u>	sion:		
<u>Gingiva</u>	<u>a:</u>		
			7
1.	Color		
2.	Consistency		
3.	Surface Texture		
4.	Size		
5.	Contour		

	28	27	26	25	24	23	22	21	11	12	13	14	15	16	17	18
Furcatio																
Mobility	·		•		•											•
Gingiva																
Plaque																
Bleeding																
Pocket																
Pocket																
Bleeding																
Plaque																
Gingiva																
Mobility																
Furcation																
	38	37	36	35	34	33	32	31	41	42	43	44	45	46	47	48

Radiographic Findings	
Diagnosis	
Differential Diagnosis	
Treatment Planning	
(a) Evaluation of the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) Root Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication	
Follow Up:	

Date	Treatment	Initials

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

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In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date

(Printed Name of Witness)	Date
(Dental Surgeon)	

ALTAMASH INSTITUTE OF DENTAL MEDICINE History & Clinical Examination

	ate: Reg No
	ersonal Information
	ame:Sex:Age:Marital Status:
	ddress:
	ontact No:Occupation:
	nief Complain:
	story of Complain:edical History:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis
	Bleeding Disorder:
	Kidney:
	Drug Allergies:

10.	Viral / Immune Disorders:			
11.	Any previous Operations / Surgical Procedo	ures:		
12.	Drugs for any Disease:			
-				
<u>Fema</u>	ıles Only:			
Pregr	nant: Y N			
ii Yes	s, Which Trimester: 1 2 3			
	y History: al History:	Υ	N	
	Past Dental Treatment			
	Bleeding while brushing/Flossing			
	2. Bleeding wille Brasiling, 11033111g			
	3. Sensitive teeth			
	4. H/O Periodontal Surgery			
	5. Wore Braces			
	6. Halitosis			
<u>Oral I</u>	Hygiene Methods			
Metho	ods of Brushing:			
Tooth	brush type:Paste/Powde	er:	_Inter-proximal Cleaning: _	
<u>Habi</u>	ts (Dental)			
	1. Smoking			

	2. Pan/ Betel nut Chewing /Others										
	3. Bruxism										
<u>. </u>	4. Mouth Breathing/ any other										
Soft T	Soft Tissue										
1.	Skin/Face										
2.	Cheeks										
3.	Frenum										
4.	Palate										
5.	Lips										
6.	Floor of Mouth										
7.	Tongue										
<u> </u>											
<u>Occlus</u>	sion:										
Gingiv	<u>a:</u>										

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
																Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

Treatment Plan	<u>ning</u>	
(a) Evaluation of	f the Cause	
(b) Education (d	c) Motivation (d) O.H. Instruction	
(e) Scaling (f) F	coot Planning	
(g) Curettage (h	n) Flap (i) Surgery	
(j) Medication _		
Follow Up:		
Date	Treatment	Initials

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

ALTAMASH INSTITUTE OF DENTAL MEDICINE

History & Clinical Examination

Dat	re: Reg No
<u>Per</u>	sonal Information
Nar	ne:Sex:Age:Marital Status:
Add	dress:
Cor	ntact No:Occupation:
Chief	Complain:
Histor	y of Complain:
Medic	cal History:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
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7.	Bleeding Disorder:						
8.	Kidney:						
9.	Drug Allergies:						
10.	Viral / Immune Disorders:						
11.	Any previous Operations / Surgical Proced	dures:					
12.	Drugs for any Disease:						
<u>Fema</u>	ales Only:						
Preg	nant: Y N						
If Ye	s, Which Trimester: 1 2 3						
	,						
Fami	ly History:						
	al History:	Υ	N				
	1. Past Dental Treatment						
	2. Bleeding while brushing/Flossing						
	3. Sensitive teeth						
	5. Sensitive teetii						
	4. H/O Periodontal Surgery						
	5. Wore Braces						
	6. Halitosis						
<u>Oral</u>	<u>Hygiene Methods</u>						
Meth	ods of Brushing:						

Toothbrush type:	Paste/Powder:	Inter-proximal Cleaning:	
Habits (Dental)			
 Smoking Pan/ Betel nut Chewing 	ng /Others		
3. Bruxism			
4. Mouth Breathing/ and	yother		
Soft Tissue			
1. Skin/Face			
2. Cheeks			
3. Frenum			
4. Palate			
5. Lips			
6. Floor of Mouth			
7. Tongue			
<u> </u>			
Occlusion:			

Gingiva:

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
														'		Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diag	nosis	
Treatment Plani	ning	
(a) Evaluation of	f the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) R	oot Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication _		
Follow Up:		
Date	Treatment	Initials

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment - with the expectation of possible advancement of my condition which may result in premature loss of teeth; (2) extraction of teeth involved with periodontal disease; and (3) periodontal surgery without prior scaling and root planing, this alternative is sometimes recommended depending upon the nature of the disease found in a specific patient.

Necessary Follow-up Care and Self-Care. I will need to come for reevaluation appointments following my periodontal scaling and root planing so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of this treatment and determine if further therapy is needed. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment since my periodontal treatment will probably not be successful without proper periodontal maintenance in the years to come.

No Warranty Or Guarantee. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help me, keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

I have been fully informed of the nature of periodontal scaling and root planing, the risks and benefits and of the possible need for periodontal surgery, the alternative treatments available, and the necessity for follow-up and selfcare. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of periodontal scaling and root planing as presented to me during consultation and in the treatment plan presentation as described in this document.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

ALTAMASH INSTITUTE OF DENTAL MEDICINE

History & Clinical Examination

Date:			Reg No	
Personal Information				
Name:	Sex:	Age:	Marital Status:	
Address:				
Contact No:		Occupation: _		
hief Complain:				
story of Complain:				

<u> Medi</u>	cal History:
L .	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
<u>2</u> .	CNS: Epilepsy Fits Syncope Nervous Disorder
-	Tits Tits Tits Nervous Disorder
3.	Liver: Hepatitis Jaundice
ı.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
5.	Rheumatic Fever: Gout-Arthritis
7.	Bleeding Disorder:
8.	Kidney:
9.	Drug Allergies:
10	. Viral / Immune Disorders:
11	Any previous Operations / Surgical Procedures:
12	Drugs for any Disease:
<u>-</u>	
<u>Fe</u>	males Only:
Pr	egnant: Y N
lf `	Yes, Which Trimester: 1 2 3
E	mily History:
	mily History: ental History: Y N

_

Soft Tissue

Skin/Face			
1.	Cheeks		
2.	Frenum		
3.	Palate		
4.	Lips		
5.	Floor of Mouth		
6.	Tongue		
Occlus Gingiv			
1.	Color		
2.	Consistency		
3.	Surface Texture		
4.	Size		
5.	Contour		

	28	27	26	25	24	23	22	21	11	12	13	14	15	16	17	18
Furcatio																
Mobility	·		•		•											•
Gingiva																
Plaque																
Bleeding																
Pocket																
Pocket																
Bleeding																
Plaque																
Gingiva																
Mobility																
Furcation																
	38	37	36	35	34	33	32	31	41	42	43	44	45	46	47	48

Radiographic Findings	
Diagnosis	
Differential Diagnosis	
Treatment Planning	
(a) Evaluation of the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) Root Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication	
Follow Up:	

Date	Treatment	Initials

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include periodontal scaling and root planing. This includes the nonsurgical scraping of tooth roots and lining of the gum, with or without medication, in an attempt to further reduce bacteria and calculus (tartar) under the gumline - with the expectation that this may not fully eliminate deep bacteria and calculus, and may not substantially reduce gum pockets. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

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(Printed Name of Patient,	Date
Parent, or Guardian)	
(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date:	Reg No
Personal Information	
Name:	Sex:Age:Marital Status:
Address:	
Contact No:	Occupation:
History of Complain:	
Medical History:	
1. CVS : Hypertension	Patient on risk of Bacterial Endocarditis Angina
MI Pacema	ker Congenital Heart Disease Ischemic Heart Disease
Using Prosthetic H	- Valve
2. CNS: Epilepsy	Fits Syncope Nervous Disorder
3. Liver: Hepatitis	Jaundice
4. Respiration: T.B.	Asthma
5. Endocrine: Diabetes	Thyroid
6. Rheumatic Fever: G	out-Arthritis

7.	Bleeding Disorder:								
8.	Kidney:								
9.	Drug Allergies:								
10.	. Viral / Immune Disorders:								
11.	Any previous Operations / Surgical Procedures:								
12.	Drugs for any Disease:								
<u>Fema</u>	ales Only:								
Preg	nant: Y N								
If Ye	s, Which Trimester: 1 2	3							
Fami	ly History:								
	al History:		Υ	N		_			
	Past Dental Treatment								
	2. Bleeding while brushing/Floss	ing							
	3. Sensitive teeth								
	4. H/O Periodontal Surgery								
	5. Wore Braces								
	6. Halitosis								
<u>Oral</u>	Hygiene Methods								
Meth	ods of Brushing:								
Tooth	nbrush type:Pa	ste/Powder:_		Inter-proxim	nal Cleaning:				

Habits	s (Dental)	
	 Smoking Pan/ Betel nut Chewing /Others 	
	3. Bruxism	
<u>. </u>	4. Mouth Breathing/ any other	
Soft T	<u>issue</u>	
1.	Skin/Face	
2.	Cheeks	
3.	Frenum	
4.	Palate	
5.	Lips	
6.	Floor of Mouth	
7.	Tongue	
<u>. </u>		
<u>Occlu</u> :	sion:	
Gingiv	<u>'a:</u>	

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
																Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																1 GORGE
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

Treatment Planning	<u>]</u>					
(a) Evaluation of th	e Cause					
(b) Education (c) M	otivation (d) O.H. Instruction					
(e) Scaling (f) Root	: Planning					
	lap (i) Surgery					
(j) Medication						
Follow Up:						
Date	Treatment	Initials				
1						

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include periodontal scaling and root planing. This includes the nonsurgical scraping of tooth roots and lining of the gum, with or without medication, in an attempt to further reduce bacteria and calculus (tartar) under the gumline - with the expectation that this may not fully eliminate deep bacteria and calculus, and may not substantially reduce gum pockets. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion

permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

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Necessary Follow-up Care and Self-Care. I will need to come for reevaluation appointments following my periodontal scaling and root planing so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of this treatment and determine if further therapy is needed. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment since my periodontal treatment will probably not be successful without proper periodontal maintenance in the years to come.

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I have been fully informed of the nature of periodontal scaling and root planing, the risks and benefits and of the possible need for periodontal surgery, the alternative treatments available, and the necessity for follow-up and selfcare. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of periodontal scaling and root planing as presented to me during consultation and in the treatment plan presentation as described in this document.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date:	Reg No
<u>Perso</u>	onal Information
Name	e:Sex:Age:Marital Status:
Addre	ess:
Conta	act No:Occupation:
Chief C	omplain:
History	of Complain:
<u>Medical</u>	l History:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:						
8.	Kidney:						
9.	Drug Allergies:						
10.	Viral / Immune Disorders:						
11.	Any previous Operations / Surgical Proced	lures:					
12.	Drugs for any Disease:						
<u>Fema</u>	ales Only:						
Preg	nant: Y N						
If Ye	s, Which Trimester: 1 2 3						
 Fami	ly History:						
<u>Dent</u>	al History:	Υ	N				
	1. Past Dental Treatment						
	2. Bleeding while brushing/Flossing						
	3. Sensitive teeth						
	4. H/O Periodontal Surgery						
	5. Wore Braces						
	6. Halitosis						
Oral	Hygiene Methods						
Meth	ods of Brushing:						

orush type:	_Paste/Powder:		_Inter-proximal Cleaning:	
(Dantal)				
(Dental)				
1. Smoking				
2. Pan/ Betel nut Chewing /	Others			
3. Bruxism				
4. Mouth Breathing/ any ot	her			
10				
<u>ue</u>				
Cheeks				
Frenum				
Palate				
Lips				
Floor of Mouth				
Tongue				
sion:				
a:				
	1. Smoking 2. Pan/ Betel nut Chewing / 3. Bruxism 4. Mouth Breathing/ any of	1. Smoking	1. Smoking	1. Smoking

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
																Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

Treatment Plan	<u>ning</u>	
(a) Evaluation o	f the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) R	oot Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication _		
Follow Up:		
Date	Treatment	Initials

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot,

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(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date	e: Reg No
<u>Pers</u>	onal Information
Nam	e: Sex:Age: Marital Status:
Addr	ress:
Cont	tact No:Occupation:
Chie	f Complain:
Histo	ory of Complain:
<u>Medi</u> 1.	ical History: CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
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7.	Bleeding Disorder:						
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10.	Viral / Immune Disorders:						
11.	Any previous Operations / Surgical Proced	lures:					
12.	Drugs for any Disease:						
<u>. </u>							
<u>Fema</u>	ales Only:						
Pregi	nant: Y N						
If Yes	s, Which Trimester: 1 2 3						
 Fami	ly History:						
	al History:	Y	N				
	1. Past Dental Treatment						
	2. Bleeding while brushing/Flossing						
	3. Sensitive teeth						
	4. H/O Periodontal Surgery						
	5. Wore Braces						
	6. Halitosis						
<u>Oral l</u>	Hygiene Methods						
Meth	ods of Brushing:						
Tooth	nbrush type:Paste/Powo	der:	Inter-proximal Clear	ning:			

Habits	s (Dental)	
	 Smoking Pan/ Betel nut Chewing /Others 	
	3. Bruxism	
	4. Mouth Breathing/ any other	
Soft T	i <u>ssue</u>	
1.	Skin/Face	
2.	Cheeks	
3.	Frenum	
4.	Palate	
5.	Lips	
6.	Floor of Mouth	
7.	Tongue	
<u> </u>		
<u>Occlus</u>	sion:	
Gingiv	<u>'a:</u>	

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
																Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

Treatment Planning						
(a) Evaluation of the Cause						
(b) Education (c)	Motivation (d) O.H. Instruction					
(e) Scaling (f) Ro	oot Planning					
(g) Curettage (h)) Flap (i) Surgery					
j) Medication _						
Follow Up:						
Date	Treatment	Initials				

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No Warranty Or Guarantee. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help me, keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

I have been fully informed of the nature of periodontal scaling and root planing, the risks and benefits and of the possible need for periodontal surgery, the alternative treatments available, and the necessity for follow-up and selfcare. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of periodontal scaling and root planing as presented to me during consultation and in the treatment plan presentation as described in this document.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date:	Reg No					
Personal Information						
Name:	Sex:Age:Marital Status:					
Address:						
Contact No:	Occupation:					
History of Complain:						
1. cvs: Hypertension MI Pacema	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina MI Pacemaker Congenital Heart Disease Ischemic Heart Disease Using Prosthetic H- Valve					
2. CNS: Epilepsy	Fits Syncope Nervous Disorder					
3. Liver: Hepatitis	Jaundice					
4. Respiration: T.B.	Asthma					
5. Endocrine: Diabetes	s Thyroid					
6. Rheumatic Fever: G	Sout-Arthritis					

7.	Bleeding Disorder:						
8.	Kidney:						
9.	Drug Allergies:						
10.	Viral / Immune Disorders:						
11.	Any previous Operations / Surgical Proced	lures:					
12.	Drugs for any Disease:						
<u>. </u>							
<u>Fema</u>	ales Only:						
Pregi	nant: Y N						
If Yes	s, Which Trimester: 1 2 3						
 Fami	ly History:						
	al History:	Y	N				
	1. Past Dental Treatment						
	2. Bleeding while brushing/Flossing						
	3. Sensitive teeth						
	4. H/O Periodontal Surgery						
	5. Wore Braces						
	6. Halitosis						
<u>Oral l</u>	Hygiene Methods						
Meth	ods of Brushing:						
Tooth	nbrush type:Paste/Powo	der:	Inter-proximal Clear	ning:			

	 Smoking Pan/ Betel nut Chewing /Others 	
	3. Bruxism	
	4. Mouth Breathing/ anyother	
Soft T	<u>issue</u>	
1.	Skin/Face	
2.	Cheeks	
3.	Frenum	
4.	Palate	
5.	Lips	
6.	Floor of Mouth	
7.	Tongue	
Occlus	sion:	

Habits (Dental)

Gingiva:

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
			'	'										'		Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diagnosis							
Treatment Planning							
(a) Evaluation of the Cause							
(b) Education (c) Motivation (d) O.H. Instruction						
(e) Scaling (f) R	oot Planning						
(g) Curettage (h) Flap (i) Surgery						
(j) Medication _							
Follow Up:							
Date Treatment Initials							

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include periodontal scaling and root planing. This includes the nonsurgical scraping of tooth roots and lining of the gum, with or without medication, in an attempt to further reduce bacteria and calculus (tartar) under the gumline - with the expectation that this may not fully eliminate deep bacteria and calculus, and may not substantially reduce gum pockets. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection,

bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment - with the expectation of possible advancement of my condition which may result in premature loss of teeth; (2) extraction of teeth involved with periodontal disease; and (3) periodontal surgery without prior scaling and root planing, this alternative is sometimes recommended depending upon the nature of the disease found in a specific patient.

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(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date	e: Reg No
<u>Pers</u>	sonal Information
Nam	ne:Sex:Age:Marital Status:
Addr	ress:
Cont	tact No:Occupation:
Chie	ef Complain:
	ory of Complain:al History:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:					
8.	Kidney:					
9.	Drug Allergies:					
10.	Viral / Immune Disorders:					
11.	Any previous Operations / Surgical Proced	dures:				
12.	Drugs for any Disease:					
<u>Fema</u>	ales Only:					
Preg	nant: Y N					
If Ye	s, Which Trimester: 1 2 3					
Fami	ly History:					
	al History:	Υ	N			
	1. Past Dental Treatment					
	2. Bleeding while brushing/Flossing					
	3. Sensitive teeth					
	5. Sensitive teetii					
	4. H/O Periodontal Surgery					
	5. Wore Braces					
	6. Halitosis					
<u>Oral</u>	<u>Hygiene Methods</u>					
Meth	ods of Brushing:					

Toothbrush type:		Paste/Powder:	Inter-proximal Cleaning:
2.	Smoking Pan/ Betel nut Chewing /0 Bruxism		
4.	Mouth Breathing/ any oth	ner	
Soft Tissu	<u>le</u>		
1. Ski	n/Face		
2. Ch	eeks		
3. Fre	enum		
4. Pa	late		
5. Lip	S		
6. Flo	oor of Mouth		
7. To	ngue		
<u>. </u>			
Occlusion	:		

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
														'		Mobility
																Gingiva
																Plaque
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																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diag	nosis				
Treatment Plani	ning				
(a) Evaluation of	f the Cause				
(b) Education (c) Motivation (d) O.H. Instruction				
(e) Scaling (f) R	oot Planning				
(g) Curettage (h) Flap (i) Surgery				
(j) Medication _					
Follow Up:					
Date	Treatment	Initials			

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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(Printed Name of Patient,	Date
Parent, or Guardian)	

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Date	e: Reg No
<u>Pers</u>	onal Information
Nam	e:Sex:Age:Marital Status:
Addr	ress:
Cont	tact No:Occupation:
Chief C	Complain:
	of Complain:
Medica	I History:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
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5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:							
8.	Kidney:							
9. Drug Allergies:								
10.	10. Viral / Immune Disorders:							
11.	Any previous Operations / Surgical Proced	dures:						
12.	Drugs for any Disease:							
<u>Fema</u>	ales Only:							
Preg	nant: Y N							
If Ye	s, Which Trimester: 1 2 3							
	,							
Fami	ly History:							
	al History:	Υ	N					
	1. Past Dental Treatment							
	2. Bleeding while brushing/Flossing							
	3. Sensitive teeth							
	5. Sensitive teetii							
	4. H/O Periodontal Surgery							
	5. Wore Braces							
	6. Halitosis							
<u>Oral</u>	<u>Hygiene Methods</u>							
Meth	ods of Brushing:							

Toothbrush type:	Paste/Powder:	Inter-proximal Cleaning:
Habits (Dental)		
 Smoking Pan/ Betel nut Chewir 	ng /Others	
3. Bruxism		
4. Mouth Breathing/ any	other	
Soft Tissue		
1. Skin/Face		
2. Cheeks		
3. Frenum		
4. Palate		
5. Lips		
6. Floor of Mouth		
7. Tongue		
<u> </u>		
Occlusion:		

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
														'		Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
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																Gingiva
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																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diag	nosis	
Treatment Plani	ning	
(a) Evaluation of	f the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) R	oot Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication _		
Follow Up:		
Date	Treatment	Initials

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection,

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(Printed Name of Patient,	Date
Parent, or Guardian)	

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Date	: Reg No
<u>Pers</u>	onal Information
Nam	e:Sex:Age:Marital Status:
Addr	ress:
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	of Complain:
Medical	l History:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
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<u>Fema</u>	ales Only:			
Preg	nant: Y N			
If Ye	s, Which Trimester: 1 2 3			
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Fami	ly History:			
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<u>Oral</u>	<u>Hygiene Methods</u>			
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Toothbrush type:	Paste/Powder:	Inter-proximal Cleaning:
Habits (Dental)		
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2. Cheeks		
3. Frenum		
4. Palate		
5. Lips		
6. Floor of Mouth		
7. Tongue		
<u> </u>		
Occlusion:		

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
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18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
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																Gingiva
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Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diag	nosis	
Treatment Plani	ning	
(a) Evaluation of	f the Cause	
(b) Education (c) Motivation (d) O.H. Instruction	
(e) Scaling (f) R	oot Planning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication _		
Follow Up:		
Date	Treatment	Initials

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I have been fully informed of the nature of periodontal scaling and root planing, the risks and benefits and of the possible need for periodontal surgery, the alternative treatments available, and the necessity for follow-up and selfcare. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of periodontal scaling and root planing as presented to me during consultation and in the treatment plan presentation as described in this document.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date	e: Reg No
<u>Pers</u>	sonal Information
Nam	ne:Marital Status:
Addı	ress:
Cont	tact No:Occupation:
History	Complain: v of Complain:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:						
8.	Kidney:						
9.	Drug Allergies:						
10.	Viral / Immune Disorders:						
11.	Any previous Operations / Surgical Pro-	cedures:					
12.	Drugs for any Disease:						
Fema	ales Only:						
Preg	nant: Y N						
If Ye	s, Which Trimester: 1 2 3						
Fami	ily History:						
	al History:	Υ	N				
	1. Past Dental Treatment						
	2. Bleeding while brushing/Flossing						
	3. Sensitive teeth						
	4. H/O Periodontal Surgery						
	5. Wore Braces						
	6. Halitosis						
Oral	Hygiene Methods						
Meth	ods of Brushing:						
Tooth	nbrush type:Paste/Po	owder:	Inter-proximal Clear	ning:			

Habits (Dental)				
 Smoking Pan/ Betel nut Chewing /Others 				
3. Bruxism				
4. Mouth Breathing/ any other				
Soft Tissue				
1. Skin/Face				
2. Cheeks				
3. Frenum				
4. Palate				
5. Lips				
6. Floor of Mouth				
7. Tongue				
<u>. </u>				
Occlusion:				
Gingiva:				

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
																Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																1 GORGE
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

Treatment Planning						
(a) Evaluation of the Cause						
(b) Education (c) Motivation (d) O.H. Instruction						
(e) Scaling (f) Root Plan	nning					
(g) Curettage (h) Flap (i) Surgery					
(j) Medication						
Follow Up:						
Date	Treatment	Initials				

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include periodontal scaling and root planing. This includes the nonsurgical scraping of tooth roots and lining of the gum, with or without medication, in an attempt to further reduce bacteria and calculus (tartar) under the gumline - with the expectation that this may not fully eliminate deep bacteria and calculus, and may not substantially reduce gum pockets. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion

permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment - with the expectation of possible advancement of my condition which may result in premature loss of teeth; (2) extraction of teeth involved with periodontal disease; and (3) periodontal surgery without prior scaling and root planing, this alternative is sometimes recommended depending upon the nature of the disease found in a specific patient.

Necessary Follow-up Care and Self-Care. I will need to come for reevaluation appointments following my periodontal scaling and root planing so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of this treatment and determine if further therapy is needed. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment since my periodontal treatment will probably not be successful without proper periodontal maintenance in the years to come.

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Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date:	Reg No
Personal Ir	<u>nformation</u>
Name: _	Sex:Age:Marital Status:
Address	S:
Contact	No:Occupation:
Chief Co	omplain:Complain:
Medical Hi	
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	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
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7.	Bleeding Disorder:					
8.	Kidney:					
9.	Drug Allergies:					
10.	Viral / Immune Disorders:					
11.	Any previous Operations / Surgical Proced	lures:				
12.	Drugs for any Disease:					
<u>. </u>						
<u>Fema</u>	ales Only:					
Pregi	nant: Y N					
If Yes	s, Which Trimester: 1 2 3					
 Fami	ly History:					
	al History:	Y	N			
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	2. Bleeding while brushing/Flossing					
	3. Sensitive teeth					
	4. H/O Periodontal Surgery					
	5. Wore Braces					
	6. Halitosis					
<u>Oral l</u>	Hygiene Methods					
Meth	ods of Brushing:					
Tooth	nbrush type:Paste/Powo	der:	Inter-proximal Clear	ning:		

Habits (Dental)				
 Smoking Pan/ Betel nut Chewing /Others 				
3. Bruxism				
4. Mouth Breathing/ any other				
Soft Tissue				
1. Skin/Face				
2. Cheeks				
3. Frenum				
4. Palate				
5. Lips				
6. Floor of Mouth				
7. Tongue				
Occlusion:				
<u>Coolacioni</u>				

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
																Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
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																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

Treatment Planning		
(a) Evaluation of the	Cause	
(b) Education (c) Mo	tivation (d) O.H. Instruction	
(e) Scaling (f) Root Plan	nning	
(g) Curettage (h) Flap (i) Surgery	
(j) Medication		
Follow Up:		
Date	Treatment	Initials

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

Date:	Reg No
<u>Persona</u>	al Information
Name: _	Sex:Age:Marital Status:
Address	S:
Contact	No:Occupation:
Chief Com	nplain:
History of 0	Complain:
Medical Hi	story:
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:							
8.	Kidney:							
9. Drug Allergies:								
10.	Viral / Immune Disorders:							
11.	Any previous Operations / Surgical Proced	dures:						
12.	Drugs for any Disease:							
<u>Fema</u>	ales Only:							
Preg	nant: Y N							
If Ye	s, Which Trimester: 1 2 3							
	,							
Fami	ly History:							
	al History:	Υ	N					
	1. Past Dental Treatment							
	2. Bleeding while brushing/Flossing							
	3. Sensitive teeth							
	5. Sensitive teetii							
	4. H/O Periodontal Surgery							
	5. Wore Braces							
	6. Halitosis							
<u>Oral</u>	<u>Hygiene Methods</u>							
Meth	ods of Brushing:							

Toothbrush type:	Paste/Powder:	Inter-proximal Cleaning:
Habits (Dental)		
 Smoking Pan/ Betel nut Chewing 	g /Others	
3. Bruxism		
4. Mouth Breathing/ any	other	
Soft Tissue		
1. Skin/Face		
2. Cheeks		
3. Frenum		
4. Palate		
5. Lips		
6. Floor of Mouth		
7. Tongue		
<u> </u>		
Occlusion:		

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
														'		Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diag	nosis	
Treatment Plann	ing	
(b) Education	of the Cause (c) Motivation (d) O.H. Instruction	
	oot Planning	
(g) Curettage (h)	Flap (i) Surgery	
(j) Medication		
rollow up		
Date	Treatment	Initials

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment - with the expectation of possible advancement of my condition which may result in premature loss of teeth; (2) extraction of teeth involved with periodontal disease; and (3) periodontal surgery without prior scaling and root planing, this alternative is sometimes recommended depending upon the nature of the disease found in a specific patient.

Necessary Follow-up Care and Self-Care. I will need to come for reevaluation appointments following my periodontal scaling and root planing so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of this treatment and determine if further therapy is needed. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment since my periodontal treatment will probably not be successful without proper periodontal maintenance in the years to come.

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date

Parent, or Guardian)				
(Printed Name of Witness)	Date			
(Dental Surgeon)	Date			

ALTAMASH INSTITUTE OF DENTAL MEDICINE

History & Clinical Examination

Date	: Reg No
<u>Perse</u>	onal Information
Nam	e:
Addr	ress:
Cont	act No:Occupation:
Histo	f Complain: ory of Complain: ical History: CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
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7.	Bleeding Disorder:						
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<u>. </u>							
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Pregi	nant: Y N						
If Yes	s, Which Trimester: 1 2 3						
 Fami	ly History:						
	al History:	Y	N				
	1. Past Dental Treatment						
	2. Bleeding while brushing/Flossing						
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<u>Oral l</u>	Hygiene Methods						
Meth	ods of Brushing:						
Tooth	nbrush type:Paste/Powo	der:	Inter-proximal Clear	ning:			

Habits (Dental)	
 Smoking Pan/ Betel nut Chewing /Others 	
3. Bruxism	
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Soft Tissue	
1. Skin/Face	
2. Cheeks	
3. Frenum	
4. Palate	
5. Lips	
6. Floor of Mouth	
7. Tongue	
<u>. </u>	
Occlusion:	
Gingiva:	

1.	Color	
2.	Consistency	
3.	Surface Texture	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
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																Pocket
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48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	
Differential Diagnosis	

<u>Treatment Plann</u>	<u>iing</u>	
	of the Cause(c) Motivation (d) O.H. Instruction	
(e) Scaling (f) Ro	oot Planning	
(g) Curettage (h)	Flap (i) Surgery	
j) Medication _		
Date	Treatment	Initials

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

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I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

ALTAMASH INSTITUTE OF DENTAL MEDICINE

History & Clinical Examination

Date:	Reg No
Perso	onal Information
Name	e:Marital Status:
Addre	ess:
Conta	act No:Occupation:
Chief C	omplain:
History of	of Complain:
<u>Medical</u>	<u>History:</u>
1.	CVS: Hypertension Patient on risk of Bacterial Endocarditis Angina
	MI Pacemaker Congenital Heart Disease Ischemic Heart Disease
	Using Prosthetic H- Valve
2.	CNS: Epilepsy Syncope Nervous Disorder
3.	Liver: Hepatitis Jaundice
4.	Respiration: T.B. Asthma
5.	Endocrine: Diabetes Thyroid
6.	Rheumatic Fever: Gout-Arthritis

7.	Bleeding Disorder:			
8.	Kidney:			
9.	Drug Allergies:			
10.	Viral / Immune Disorders:			
11.	Any previous Operations / Surgical Proced	ures:		
12.	Drugs for any Disease:			
<u> </u>				
<u>Fema</u>	ales Only:			
Preg	nant: Y N			
If Ye	s, Which Trimester: 1 2 3			
Fami	ly History:			
<u>Dent</u>	al History:	Υ	N	
	1. Past Dental Treatment			
	2. Bleeding while brushing/Flossing			
	3. Sensitive teeth			
	4. H/O Periodontal Surgery			
	5. Wore Braces			
	6. Halitosis			
<u>Oral</u>	Hygiene Methods			
Meth	ods of Brushing:			

Toothbrush type:	Paste/Powder:	Inter-proximal Cleaning:
Habits (Dental)		
 Smoking Pan/ Betel nut Chewing 	g /Others	
3. Bruxism		
4. Mouth Breathing/ any	other	
Soft Tissue		
1. Skin/Face		
2. Cheeks		
3. Frenum		
4. Palate		
5. Lips		
6. Floor of Mouth		
7. Tongue		
<u> </u>		
Occlusion:		

Gingiva:

1.	Color	
2.	Consistency	
3.	Surface Texture	
1	Sino	
4.	Size	
5.	Contour	

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
																Furcation
														'		Mobility
																Gingiva
																Plaque
																Bleeding
																Pocket
																Pocket
																Bleeding
																Plaque
																Gingiva
																Mobility
																Furcation
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

Investigation Required	
Radiographic Findings _	
Diagnosis	

Differential Diagnosis							
Treatment Planning							
(a) Evaluation of the Cause (b) Education (c) Motivation (d) O.H. Instruction (e) Scaling (f) Root Planning							
(g) Curettage (h) Flap (i) Surgery						
(j) Medication							
Follow Up:							
Date	Treatment	Initials					

ALTAMASH INSTITUTE OF DENTAL MEDICINE DEPARTMENT OF PERIODONTOLOGY

CONSENT FOR PERIODONTAL SCALING AND ROOT PLANING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include periodontal scaling and root planing. This includes the nonsurgical scraping of tooth roots and lining of the gum, with or without medication, in an attempt to further reduce bacteria and calculus (tartar) under the gumline - with the expectation that this may not fully eliminate deep bacteria and calculus, and may not substantially reduce gum pockets. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

Expected Benefits. The purpose of periodontal scaling and root planing is to reduce infection and inflammation around the teeth. However, periodontal surgery is still often necessary to help me keep my teeth in the operated areas and to make my oral hygiene more effective.

Principal Risks and Complications. I understand that occasionally complications may result from the periodontal scaling and root planing, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Also possible may be transient but on occasion

permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, accidental swallowing of foreign matter or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated.

In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment - with the expectation of possible advancement of my condition which may result in premature loss of teeth; (2) extraction of teeth involved with periodontal disease; and (3) periodontal surgery without prior scaling and root planing, this alternative is sometimes recommended depending upon the nature of the disease found in a specific patient.

Necessary Follow-up Care and Self-Care. I will need to come for reevaluation appointments following my periodontal scaling and root planing so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of this treatment and determine if further therapy is needed. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment since my periodontal treatment will probably not be successful without proper periodontal maintenance in the years to come.

No Warranty Or Guarantee. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help me, keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

I have been fully informed of the nature of periodontal scaling and root planing, the risks and benefits and of the possible need for periodontal surgery, the alternative treatments available, and the necessity for follow-up and selfcare. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of periodontal scaling and root planing as presented to me during consultation and in the treatment plan presentation as described in this document.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

(Printed Name of Patient,	Date
Parent, or Guardian)	

(Printed Name of Witness)	Date
(Dental Surgeon)	Date

EVALUATION FORM

S.No	Date	Patient's Name	OPD#	Procedure	Competency Level	Sign

Key for Competency:

O = Observed

PS = Performed under supervision

PI = Performed independently

ASSESSMENT FORM

AREAS TO BE ASSESSED	POOR (1)	FAIR (2)	AVERAGE (3)	GOOD (4)	EXCELLENT (5)
ATTENDANCE					
ATTENDANCE					
BEHAVIOUR					
PATIENT HANDLING					
CASE PRESENTATION					
CLINICAL PERFORMANCE					
RESEARCH WORK					
TOTAL					

Student's Name:						
Assessor's Name:						
Clinical Settings:	In- <u>pati</u> ent <u>O</u>	PD				
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Citation I Bunklamer	Bata Canatatistas	Constitue - Feebras				
Clinical Problems:	Pain Sensitivity	Swelling Esthet	ics			
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		Katii	ng Scale for N			
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			Clinical Rotation	:		
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Category						
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			Assessor's Position	on: PG	DEMO AP PRO)F
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assessor with any traine	:e 					
New or FU:	New FU	Focus or Clinical				
New of 10.	Encount					
Number of times patien	t 0 1-4	4 >5				
Seen before by trainee:	Number of Previous					
mini-CEXs observed by	0 1	2 3 4 5-9	>9 Complexity	y of Case: Low		
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Level usii	ig the scale below	L	1 2	3 4	5 6	;
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appropriate question to		., r			•	
					Highly Satisfied	
				7 🔲	8 9	
faction						
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Student's Name:											
Assessor's Name:											
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Clinical Problems: Pa Adequate info, responds pro	•	Swelling E & non verbal									
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Sequence; examination app						_					
Explains to patient; sensitive	e to patients cor	mfort,			, _	7					
modesty					J L						
Communication Skills: Explo	ores patient's pe	erspective,									
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Plan/therapy with patient Clinical Judgment: Makes a	innronriate dias	nosis &									
Formulates suitable manage			s/								
Performs appropriate diagn <u>Professionalism:</u> Shows resp	ostic studies, co pect, compassio	nsiders risk, I n, empathy,									
Establishes trust; attends to						L					
Respect, confidentiality. Bel Aware of relevant legal fran											
limitations.	ieworks. / ware	. 01			7						
Organizations/Efficiency; Pr	iorities; is timel	y. Succinct.									
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Judgment, synthesis, caring	, effectiveness.					_					
Efficiency, appropriate use of											
	C Please mark t	his if you hav	e not obs	erved the	behavior					nment	
Anything especially good?						Sugges	stions for I	mprove	<u>ement</u>		
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Student's Name:		<u></u>				
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Assessor's Name:											
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