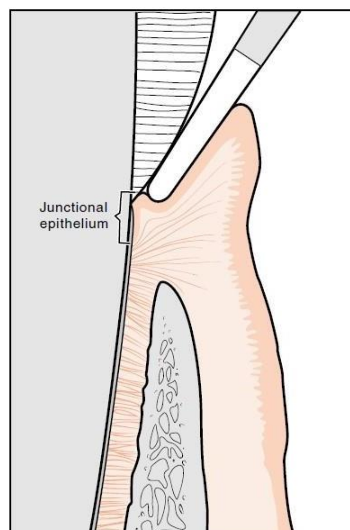
ALTAMASH INSTITUTE OF DENTAL MEDICINE

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,

M r . / M i s s . ____

has completed his / her clinical rotation in the department 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.
- Late work will not be signed.
- Students are self-responsible for their belongings (Instrument, Materials, Books, Mobile & Money etc) in the OPD territory.
- 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 ☐ Fits ☐ 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: ____

Dental History: Y N

	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)

1. Smoking ☐
2. 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: ______

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
																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 ______________________________

<u>Treatment Planning</u>

(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

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 ☐ Fits ☐ 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: ______________________________

	Y	N
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Dental History:

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)

1. Smoking ☐
2. 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:

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
																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

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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, 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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____

(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: ______________________________

____

Chief Complain: ____

History of Complain: ____

Medical History:

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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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _____________Paste/Powder:__________Inter-proximal Cleaning: ________

Habits (Dental)

1. Smoking ☐

2. 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: ____________________

____

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
																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

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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. ____________________

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 ☐
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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: ______________________________

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ______________________________

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking ☐
2. Pan/ Betel nut Chewing /Others ☐
3. Bruxism ☐
4. Mouth Breathing/ anyother ☐

. ____

Soft Tissue

1. Skin/Face ☐
2. Cheeks ☐
3. Frenum ☐
4. Palate ☐
5. Lips ☐
6. Floor of Mouth ☐
7. Tongue ☐

. ____

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
																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.

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(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: _______________________________

____

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 ☐ Fits ☐ 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: ______________________________

Dental 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 ☐ ☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: __________

Habits (Dental)

1. Smoking ☐
2. Pan/ Betel nut Chewing /Others ☐
3. Bruxism ☐
4. Mouth Breathing/ any other ☐

. ____

Soft Tissue

Skin/Face

1. Cheeks
2. Frenum
3. Palate
4. Lips
5. Floor of Mouth
6. Tongue

.

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
																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.**

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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.

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(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: _______________________________

____

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking
2. 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:

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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																Gingiva
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																Bleeding
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																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.

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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, 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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(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: ______________________________

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 ☐
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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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking ☐
2. Pan/ Betel nut Chewing /Others ☐
3. Bruxism ☐
4. Mouth Breathing/ any other ☐

. ____

Soft Tissue

Skin/Face ☐

1. Cheeks ☐
2. Frenum ☐
3. Palate ☐
4. Lips ☐
5. Floor of Mouth ☐
6. Tongue ☐

. ____

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
																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

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(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: ______________________________

____

Chief Complain: ____

History of Complain: ____

Medical History:

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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:** ____

. ____

<u>Females Only:</u>

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	☐	☐

<u>Oral Hygiene Methods</u>

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________

Habits (Dental)

1. Smoking ☐
2. 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: ______________________________

____

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
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																Plaque
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																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.

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(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: ______________________________

____

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking
2. Pan/ Betel nut Chewing /Others
3. Bruxism
4. Mouth Breathing/ anyother

.

Soft Tissue

1. Skin/Face
2. Cheeks
3. Frenum
4. Palate
5. Lips
6. Floor of Mouth
7. Tongue

.

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
																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.

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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,

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 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.

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(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: _______________________________

____

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: ______________Paste/Powder:__________Inter-proximal Cleaning: ________-__

Habits (Dental)

1. Smoking ☐
2. 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: ____

____

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
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																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) 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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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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(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: ______________________________

____

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 ☐
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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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: ______________Paste/Powder:__________Inter-proximal Cleaning: ________-__

Habits (Dental)

1. Smoking ☐
2. 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: ____

____

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
																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

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(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: ______________________________

____

Chief Complain: ____

History of Complain: ____

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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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking ☐
2. 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: ____

____

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
																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.

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(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: _______________________________

____

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________

Habits (Dental)

1. Smoking ☐
2. 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: ____

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
																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.

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(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: ______________________________

____

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking
2. 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: ____

____

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
																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.

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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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(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: ______________________________

____

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: ______________Paste/Powder:__________Inter-proximal Cleaning: ________

Habits (Dental)

1. Smoking ☐
2. 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: ____

____

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
																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.

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(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: ______________________________

____

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 ☐
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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:** ____

. ____

<u>Females Only:</u>

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	☐	☐

<u>Oral Hygiene Methods</u>

Methods of Brushing: ____

Toothbrush type: _______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking ☐
2. 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: ____________________

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
																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

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 ☐ Fits ☐ 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: ____

Dental 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	☐	☐

Oral Hygiene Methods

Methods of Brushing: ____

Toothbrush type: ______________Paste/Powder:__________Inter-proximal Cleaning: ________ __

Habits (Dental)

1. Smoking
2. 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: ____

____

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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Diagnosis____

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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

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					
BEHAVIOUR					
PATIENT HANDLING					
CASE PRESENTATION					
CLINICAL PERFORMANCE					
RESEARCH WORK					
TOTAL					

Student's Name: ______________________________

Assessor's Name: ______________________________

Clinical Settings: **In-patient** **OPD**

Clinical Problems: **Pain** **Sensitivity** **Swelling** **Esthetics**

Rating Scale for Mini CEX

M. No: ____________________ Year: ______________

Clinical Rotation: ____

Category

D. Erupt. Trauma Missing teeth LMO B. Gums TMJ Ulcers TG

History Diagnosis Management Explanation

Assessor's Position: PG DEMO AP PROF

Average High

assessor with any trainee

New or FU: **New FU Focus or Clinical Encounter:**

Number of times patient 0 1-4 >5

Seen before by trainee: Number of Previous

mini-CEXs observed by 0 1 2 3 4 5-9 >9 Complexity of Case: Low

Please grade the following areas for__________ ___________Level using the scale below	Below Expectations		Borderline	Meets Expectations	Above Expectations		U/C
	1	2	3	4	5	6	
History taking: Facilities patient's telling of story, appropriate question to obtain accurate				effectively uses			

Highly Satisfied

7 8 9

faction

CEX 1 2 3 4 5 6 7 8

9 Have you had training in the use of this assessment tool? No Yes: face to face Yes:

Time taken for observation Min:

Assessor's Signature:

Assessor's Name: Date:____________________ Time taken for feedback (in minutes):

Student's Name: ______________________________

Assessor's Name: ______________________________

Clinical Settings: **In-patient** **OPD**

Clinical Problems: **Pain** **Sensitivity** **Swelling** **Esthetics**

Adequate info, responds properly to verbal & non verbal cues

Physical Examination Skills: Follows efficient, logical Sequence; examination appropriate to clinical problem, Explains to patient; sensitive to patients comfort, modesty

Communication Skills: Explores patient's perspective,

Jargon tree, open and honest, empathetic, agrees Mx Plan/therapy with patient

Clinical Judgment: Makes appropriate diagnosis & Formulates suitable management plan; selectively orders/ Performs appropriate diagnostic studies, considers risk, benefits

Professionalism: Shows respect, compassion, empathy,

Establishes trust; attends to patient's needs of comfort, Respect, confidentiality. Behaves in an ethical manner, Aware of relevant legal frameworks. Aware of limitations.

Organizations/Efficiency; Priorities; is timely. Succinct.

Summarizes

Overall Clinical Care: Demonstrates satisfactory clinical Judgment, synthesis, caring, effectiveness.

Efficiency, appropriate use of resources, balances risk and Benefits. Awareness of own limitations.

***U/C Please mark this if you have not observed the behavior and therefore feels unable to comment**

Anything especially good?	Suggestions for Improvement
Agreed Action:	

Trainee satisfaction with Mini-CEX Not at all 1 2 3 4 5 6 7 8 9 Highly Satisfied

Assessor Satisfaction With Mini-CEX 1 2 3 4 5 6 7 8 9

Have you had training in the use of this assessment tool? No Yes: face to face Yes:

Time taken for observation Min.

Assessor's Signature:

Assessor's Name: Date:____________________ Time taken for feedback (in minutes):

Student's Name: ______________________________

Assessor's Name: _____________________________

Clinical Settings: **In-patient** **OPD**

Clinical Problems: **Pain** **Sensitivity** **Swelling** **Esthetics**

Written Training Yes: Web/CD room

Rating Scale for Mini CEX

M. No: __________________ Year: _____________

Clinical Rotation: ____

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Time taken for observation Min:

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Highly Satisfied
7 8 9

faction
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