Karin Cross
RDHAP LIC # 1010
Registered Dental Hygienist in Alternative Practice
phone: (805)607- 0992
crosskarin6@gmail.com

TREATMENT CONSENT FORM

After careful examination, The Register Dental Hygienist in Alternative Practice (Karin Cross) has informed me that I need: (a) Dental Prophylaxis (b) Periodontal Maintenance (c) Scaling and Root Planning. (d) Topical fluor varnish.

The purpose of this therapy is to prevent or reduce some causes of periodontal disease to a level more manageable by my individual immune system. I understand there are some risks, which may include but are not limited to swelling, pain,

Bleeding, sensitivity to cold or hot after treatment.

NO WARRANTY AND SELF RESPONSIBILITY

There is no method currently available that will predict how the gums and bone will heal following any periodontal treatment. Because each patient's condition is unique. Long-term success may not occur. In addition, the success of treatment can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, medications, and inadequate oral hygiene. I understand that after the proposed treatment has been completed, constant monitoring of my condition will be necessary. This will mainly consist of regular dental cleaning depending on what my hygienist recommends. I understand that my personal hygiene is the key to prevention and successful treatment. If satisfactory plaque control is not maintained, recurrence of periodontal disease is likely.

I certify that I have read and understand the above consent and agree to start treatment as proposed by my RDHAP.

Patient or Responsibility party name: _____

Signature: _____ **Date:** _____