

Dental Laser ANAP Informed Consent and Authorization for Treatment

1. I understand that the Food and Drug Administration (FDA) have cleared dental lasers marketed and sold in the United States for marketing for use in dentistry.
2. I have been presented with the laser treatment plan and fees-for-treatment. I have been informed of other methods of treatment and the alternatives. The expected results and risks of the proposed treatment (and/or no treatment) have been explained to me.
3. I understand there is no guarantee of success or permanence of the treatment.
4. I understand that dental conditions in my mouth can change and alter the proposed treatment plan.
5. I understand that smoking and/or non-moderate use of alcohol can adversely affect gum tissue healing. Observation has shown that excesses in any of the above may limit the longevity and prognosis of the Laser ANAP treatment. It has been observed that smokers tend to heal **HALF** as well and relapse **TWICE** as often as non-smokers following any periodontal therapy. I understand that calcium balance and hormones can affect the continued loss of bone.
6. I understand that any time teeth are manipulated, whether by a mechanical drill or laser, there is always the possibility and risk that Root Canal Therapy may be necessary. I realize that in spite of observing every reasonable precaution, prior nerve damage, infection, or tooth trauma may have pre-existed in the tooth.
7. I understand that anytime that soft tissue is manipulated, whether by traditional dental technology, or laser dentistry, there is always a possibility and risk of unexpected and undesirable side effects.
8. “Spaces” between your teeth can result from reduction of inflammation, swelling, and the removal of diseased tissue after the LANAP treatment. These spaces usually fill in over time, and again, bite adjustment is critical to making sure the teeth and the “papilla” is not traumatized and can regrow.
9. “Occlusal adjustment” and “occlusal equilibration” has been fully explained to me. I have had the opportunity to ask questions, and I fully understand that occlusal adjustments require my 100% cooperation and compliance. It has been explained to me that failure to complete all phases of occlusal adjustments and equilibration may result in oral-facial pain, temporal mandibular joint dysfunction (TMJ) sore and painful teeth; and that it has been explained to me that until the teeth have been fully adjusted and/or equilibrated I may experience transitional TMJ pain, muscle soreness, headaches, tooth pain, tooth sensitivity, and cheek biting. I understand adjusting crowns can remove porcelain, expose metal and/or tooth structure, and requiring the replacement of any and all crowns.
10. I understand that “high technology” dentistry, including laser therapy, may be considered “investigational” or “experimental” and may not be reimbursed by some insurance companies, and I must anticipate paying 100% of any such treatment.
11. I understand that insurance reimbursement is only an estimate. I am ultimately responsible for any fees incurred during treatment. I understand this office does not operate on the assumption that insurance will reimburse me for the treatment rendered.
12. I understand that this office is performing this treatment in my own best interests.
13. I have read and agreed to the foregoing. I have had the opportunity to ask treatment related questions and have been advised of the risks and benefits of treatment, including the use of local anesthesia and dental lasers.
14. I understand that it is necessary to complete all phases of recommended treatment, and agree to do so.
15. I, _____, authorize the performance, upon myself, of dental treatment using dental lasers, which treatment will be performed by Bradford L. Klassman, DMD

Patient Signature

Date

Witness

Date