BRADFORD L. KLASSMAN, D.M.D.

DELAWARE PERIODONTICS
Specializing in Periodontics & Implantology

Patient Information and Consent for Treatment

Dr. Klassman has recommended that I have the following procedure(s) completed:

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1) I have been informed and I understand the purpose and the nature of the surgery.
2) I have further been informed of the possible risks and complication with surgery, drugs, and anesthesia. Such complications include pain, swelling infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medication used, etc.
3) My doctor has carefully examined my mouth. Alternatives to treatment have been explained.
4) I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, and sensitivity, looseness of teeth, followed by necessity of extraction.
5) I agree to the type of anesthesia recommended.
6) I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.
7) To my knowledge, I have given an accurate report of my physical and dental health history. I have also reported any prior allergic or unusual reactions or any other condition related to my health.
8) I consent to photography, filming, recording and x-ray of the procedure being preformed.
9) I request and authorized medical/dental services for me, including surgery and dental implants. I fully understand that during, and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant in the judgment of the doctor, additional or alternative treatment pertinent to the success or comprehensive treatment. I also approve and modification in design, material, or care, if it is felt this is for my best interest.

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Signature of Doctor Signature of Patient/Guardian

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Witness Date

P: Patient Info & Consent 4-03