Perio Protect Method™ Periodontitis Treatment Regimen

INITIAL CHARGES			
Panoramic radiograph			$__________
Bitewing radiograph			$__________
Oral Examination			$__________
Complete pocket depth analysis			$__________
Oral Images			$__________
PERIODONTITIS			
Perio Tray®		# of sets ____ x $_______ =	$__________
FUTURE ESTIMATED CHARGES			
Duplicate Perio Trays®			$__________
Perio maintenance		____ x $________ =	$__________
Complete pocket depth analysis		____ x $________ =	$__________
Debridement			$__________
Scale and root planing	(quadrant)	____ x $________ =	$__________
Scale and root planing	(1-3 teeth)	____ x $________ =	$__________
Prophylaxis			$__________
Surgery	(quadrant)	____ x $________ =	$__________
	(per site)	____ x $________ =	$__________
TOTAL			$__________

Prices are good for 6 months and subject to change at any time without notice.

INFORMED CONSENT

I have been informed I have periodontal disease. I understand that periodontal disease is an infection process that may lead to the destruction of gum tissue, bone supporting my teeth, and that the teeth may be seriously damaged or lost if treatment is not rendered. I understand there may be a relationship between periodontal disease and other systemic diseases such as heart problems, systemic infections or other health related matters.

__________Initial

I understand and accept the following:

1. There is no specific warranty or guarantee that periodontal treatment will reach an ideal result.
2. Treatment of periodontal care may be subject to factors beyond the doctor's control.
3. A limited number of problems fail to respond to mechanical, biochemical, & medical treatment.
4. Some problems may arise that require additional services beyond those discussed here.
5. There may be additional charges if unforeseen treatments are determined necessary.
6. I understand that Dr. __________________ is not a board certified periodontist.

__________Initial

I give permission for any records made in the process of these proceedings to be used for the purpose of research, education, or publication in professional journals or other media. Please note that Dr. __________ may not condition (withhold or refuse) treating you on whether you give permission for record usage. Additionally, you may change your mind and revoke (take back) this Authorization at any time without any penalty or change in your treatment. To revoke this Authorization, you must write a letter to the doctor with your request to revoke authorization.

__________Initial

I have been informed of probable complications of periodontal treatment (including the possible need for surgery), anesthesia or adverse effects that might occur. I have read and fully understand this document as given to me and all of my questions have been satisfactorily answered. By signing this Informed Consent and Periodontal Care Contract, I hereby agree to accept and abide by all conditions, treatments, and policies as set forth in this document.

__________Initial

Signature______________________________Date____________Witness________________________