Dental Wellness and Health
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I, (print name)_____, hereby authorize Dr. Chahine at Dental Wellness and Health to perform periodontal surgery on my gums (and bone).

I have been informed of the need to have the surgery and the details of the procedure have been explained to me, and I fully understand them.

I understand that following the completion of the surgery there may be a period of discomfort accompanied by some bleeding, swelling and pain. I have been made aware that smoking will jeopardize the healing process after surgery.

I understand additional complications, although rare, may occur.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the surgery, I agree to report them to the office as soon as possible. In case of an acute emergency and in the event you cannot reach this office or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, and reporting to the office any change in my health status.

In case of an acute emergency and in the event I cannot reach this office or we have not returned my call in a reasonable amount of time, I should proceed to the nearest emergency room for medical attention.

I acknowledge that no guarantees or assurances have been given by anyone. Alternative treatment plans have been fully explained to me along with possible outcomes and risks.

I have been given ample time to discuss the procedure with the doctor and have had all of my questions and concerns answered to my satisfaction

Patient's Signature (Or Guardian if a Minor)	Doctor's Signature
Witness's Signature	Date