VO DENTISTRY
GEORGIA ORTHODONTIC CARE
1605 Buford Dr., Lawrenceville, GA 30043
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LASER TREATMENT CONSENT

Diagnosis and recommended treatment: After careful oral examination of my condition, Dr. _____ has informed me that soft tissue laser gingivectomy / tooth uncover can be beneficial to my dental health. I understand that despite his best efforts, a conventional open flap surgery may be needed. If that should be the case I am aware that I will be referred to a specialist. Patient compliance is extremely important The use of antibiotics and antimicrobial rinse is also an important part of the procedure and must be taken as prescribed.

Principal Risks and Complications: Any time the oral soft and hard tissues are manipulated, whether by drill, scalpel or laser, there is always a possibility and risk of unexpected and undesirable side effects. These complications, although rare, include but are not limited to: postsurgical infection, swelling, bleeding, headache, TMJ (jaw joint) pain, tooth/gum pain, tooth sensitivity to hot, cold and sweets; shrinkage of gum tissues, muscle soreness, soft tissue numbness, and /or cracking of the corners of the mouth. The lasers are classified as tissue cutting lasers and pose a significant risk to your eyes. These lasers are very powerful and can travel for great distances through air, non-filtering glass and semi-transparent materials. You must understand that it is essential to wear your protective eye wear at all times during the procedure and you will only remove them when directed by the doctor. Vision damage from these lasers may be debilitating and permanent.

I have had the opportunity to ask treatment related questions and have been advised of the risks and benefits of treatment. I certify that I have read and fully understand this document and authorize Dr. _____ to perform the laser surgery as recommended.

Patient Name_____

Patient/Guardian Signature _____ Date_____

Witness _____ Date_____