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# Laser Ablation New Attachment Procedure
# LANAP CONSENT FOR TREATMENT

The Health Sciences continue to make remarkable advances in technology and techniques. These efforts to develop and introduce improvements over current health care treatments, are ultimately intended for the benefit of prospective patient candidates. An essential element in these efforts is to communicate all essential information to patient candidates, so that the prospective patient is able to make a knowledgeable decision. With this premise in mind, all of the pertinent facts involved in the cooperation between the surgeon, and the prospective patient is listed in detail below, so that there is a full disclosure of the procedures and complete comprehension by the patient. It is necessary that each patient read, understand, and sign the following form before proceeding with the Laser Ablation New Attachment Procedure--LANAP.

## Diagnosis:

I have consulted with my provider because I seek a solution to my dental problem by using the laser to treat the gum disease that has been diagnosed as needing LANAP.
I acknowledge that doctor has carefully examined my mouth. In his opinion, dental subgingival excision with a contact laser fiber may solve the problems from which I have been suffering.
I understand that in his experience a large percentage of LANAP cases (87%) have not needed retreatment for more than five years barring any unforeseen health or accident problems. There are limited long term studies of the partially edentulous situation. LANAP seem to be more predictable than other types of dental gum surgery.

## Alternative Treatment:

My doctor has explained other alternative periodontal surgical procedures such as Widman Flap, cut and sew and other methods. I hereby state that I have tried or considered conventional methods of periodontal surgery and regard them to be unsatisfactory for me.

## Expected Results and No Guarantee:

I acknowledge that the doctor has explained that optimum results with LANAP will depend on the individual body response of each person. There is no method in the present knowledge to guarantee the healing capabilities of any patient following treatment by LANAP.
My doctor has stated 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 of the results from the LANAP treatment. I understand that calcium balance and hormones can affect the continued loss of bone.

## Principle Risks and Complications:

I understand that LANAP involves one or more mouth surgeries. I have been informed of the complications of the surgery, anesthesia, and necessary drugs which are used. I am aware that there could there could be pain, swelling, infections, discoloration, and numbness-- the exact duration which may not be determinable. I understand that after adequate healing some areas may need to be spot treated with LANAP and occlusal adjustments.

Occlusal adj. and occlusal equilibration has been fully explained to me. I have had the opportunity to ask questions, and I fully understand that occlusal adjustments and equilibration 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.

I am further advised that I may receive an explanation of all risks and treatment(s) prior to starting, as well as any other questions during the progress of my treatment, just by asking Doctor.

## Necessary Follow-up and Self Care:

I understand it is very important to maintain a good food and fluid intake during treatment. I understand that I should eat soft foods for the next seven days on the treated side (i.e. eggs, yogurt, cottage cheese, shakes, ice cream, etc) I understand that enjoying a normal diet is recommended on the untreated side only.

My doctor has detailed the methods and importance of oral hygiene. I agree to cooperate in order to accomplish my personal home care as instructed by my doctor or his hygienist. I further agree to follow the doctors diet recommendations.

My doctor has explained that it will be my responsibility to report to his office every three (3) months, or at any other times he may recommend to carefully check the status of my LANAP treatment. Regular hygiene appointments will be made for follow-up examinations subsequent to the first six (6) months of the LANAP treatment

## Discussed Consequences of Non- Treatment:

My Dr. has explained that if no treatment is done the following sequences of events can happen:

A. Where no treatment is undertaken, further gum and bone degeneration of the supporting tissues can continue, increasing the severity of, and/or adding to, the problems presently suffered by the patient to include:

1. Loss of teeth due to traumatic occlusion and/or loss of vertical bone support.
2. Infections in the gums and bone such as ANUG.
3. Tarter/calculus buildup causing loss of vertical bone support.

B. Where only groups of teeth are missing:

1. None replacement of teeth -- in areas where excessive chewing forces exist -- may cause pronounced loss of bone, and gum disease around the remaining teeth.
2. Patient may replace teeth with conventional removable partial dentures.

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## Consent to Treatment:

- [ ] I submit that I have given an accurate report on my health history. To my best knowledge I have not withheld any information regarding my medical or mental health. Any previous allergic or unusual reactions to drugs, foods, insect bites, anesthetics, pollens, dust, or any material or condition have been willingly offered to the doctor for my complete health history.

- [ ] If Doctor considers my case appropriate, I hereby give authorization for photos to be taken of my mouth during the course of LANAP treatment. It has been explained that these photos, slides, or X-rays may be used in teaching other dentists for the advancement of LANAP in dentistry.

- [ ] I understand that Doctor will do the very best according to all of the latest principles of Laser dentistry to perform LANAP. Because of continuing progress in LANAP dentistry I authorize any modifications in designs, materials, or care -- if in his experience and professional judgment he feels it is for my best interest

- [ ] I understand that is necessary to complete all phases of recommended treatment, and agree to do so.

- [ ] With full understanding, I authorize Doctor and the LANAP team to perform dental services for me, including LANAP and other surgery deemed necessary for the planned treatment. I will also agree to the use of local or general anesthetic, sedation, and analgesia depending on the judgment of the surgeon involved in my case. Doctor has explained that if there is a need for someone to drive me from the doctors office following surgery I am to arrange this myself. I agree not to operate a motor vehicle or work for 24 hours or until fully recovered form the effects of the anesthesia or drug given me for my care, if it should be necessary.

Response Date: ____________