521 4th St. – Havre, MT 59501-3649 ** Phone 406-395-4305 Fax 406-395-5643

Denial of Service for Scaling and Root Planing (Deep Cleaning)

Patient:___________________________________Doctor:_________________

It has been recommended by my general dentist at the Bullhook Dental Clinic that I receive a deep cleaning including scaling and root planning to treat the periodontal disease (gum disease) negatively affecting my oral health. I understand that by not receiving treatment my disease state will **NOT** stop and will progressively worsen until all my teeth are lost. The following are potential risks associated with not receiving treatment:

1. Pain
2. Infection
3. Bleeding Gums
4. Swelling
5. Halitosis (Bad Breath)
6. Loose Teeth
7. Loss of Supporting Bone
8. Loss of teeth

By signing below I acknowledge that I have read the informed consent form for scaling and root planning. I understand that a conventional cleaning (Adult Prophylaxis) will not positively benefit my oral condition and will **NOT** be offered as a service to me. I acknowledge that all the risks of not receiving treatment have been explained to me, all of my questions have been answered and **I DENY THE TREATMENT OF SCALING AND ROOT PLANING.**

Patient Signiture_______________________________________Date:____________

Patient Printed Name:___________________________________Date____________

Witness:____Date:___________

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