Patient Informed Consent Form

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 are 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 LAPIP™ treatment:

1. I have had a consultation with Dr._____ pertaining to my desire to treat the disease around my dental implant(s), which has been diagnosed as needing LAPIP™ treatment, which involves the use of a laser.

2. I acknowledge that Dr. _____ has carefully examined my mouth and diagnosed me with peri-implant disease around my dental implant(s). The doctor expressed his opinion that LAPIP™ treatment may solve the problems around my dental implant from which I have been suffering. Treatment of concomitant periodontal disease is critical to improve prognosis of the LAPIP™ treatment.

3. Dr. _____ has explained other alternative peri-implant surgical procedures such as flap surgery, guided tissue regeneration, cut and sew, and other methods. I hereby state that I have tried or considered conventional methods of peri-implant surgery and regard them to be unsatisfactory for me.

4. Dr. _____ has explained that no treatment is an option with potential consequence of loss of implant and progressing infection.

5. I acknowledge that Dr. _____ has explained that optimum results with LAPIP™ treatment depends on the individual body response of each person. There is no method in present knowledge to guarantee the healing capabilities of any patient following LAPIP™ treatment

6. Dr. _____ has stated that smoking and/or non-moderate use of alcohol can adversely affect gum tissue healing. I am aware that observations have shown that excesses of smoking and alcohol consumption may limit the longevity of the LAPIP™ treatment. I understand that calcium balance and hormones can affect the continued loss of bone.

7. Dr. _____ has detailed the methods, stressed the importance of proper oral hygiene, and explained how critical it is for optimal healing following LAPIP™ treatment. I agree to comply with the methods explained to me as instructed by Dr. _____ or his/her hygienist. I further agree to follow Dr. _____'s diet recommendations.

8. Dr. _____ has explained that if I choose not to undergo LAPIP™ treatment then the following sequences of events can happen:

    a. Where no treatment is undertaken, further degeneration of the supporting tissues (gum and bone) can continue, increasing the severity of, and/or adding to, the problems presently suffered by the patient to include:
        i. Loss of dental implant due to traumatic occlusion and/or loss of vertical bone support.
        ii. Infections in the gums and bone such as Acute Necrotizing Ulcerative Gingivitis (ANUG).
        iii. Tartar/calculus buildup causing loss of vertical bone support.

    b. Where groups of teeth are missing;
        i. Not replacing lost failed implants, in areas where excessive chewing forces exist, may cause pronounced loss of bone and gum disease around the remaining teeth/implants.
        ii. Replacement of teeth/implants with conventional removable partial dentures may be necessary.

9. Dr. _____ has explained that it is my responsibility to report for further treatment and hygiene appointments, at least once every three (3) months or at any other time the doctor requires me to. I understand these visits are for the doctor to carefully check the status of my LAPIP™ treatment.

10. 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, latex (rubber), pollens, dust, or any material or condition have been willingly offered to the doctor for my complete health history.

11. I understand that LAPIP™ treatment involves one or more mouth surgeries. I have been informed of the complications of the surgery, anesthesia, and other necessary drugs used as part of the treatment. I am aware that there could be pain, swelling, infections, discoloration, numbness, spaces between the teeth/implant crowns, tissue shrinkage, recession of the gums, and exposure of implant stem and root surfaces of adjacent teeth - the exact duration of which may not be determinable. I understand that after adequate healing some areas may need to be spot-treated with LAPIP™ treatment and occlusal adjustments.

12. I understand that "severe" gum disease (Case Type III & IV) with "double digit" millimeter pocket measurements (e.g. 10mm or more) will require "double" or a subsequent re-treatment at the same fee as the first fee-for-service, typically on a implant-by-implant basis, but could involve the entire mouth as determined by the state of active disease.

13. "Occlusal adjustment" and "occlusal equilibration" have 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, temporomandibular joint dysfunction (TM), sore and painful teeth. It has also been explained that until the teeth/implant crowns have been fully adjusted and/or equilibrated I may experience transitional temporomandibular joint 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 can require the replacement of any and all crowns. I understand that occlusal adjustment is part of the LAPP™ treatment and is an ongoing part of my regular examination appointments.

14. I understand that my implant crown may need to be fully removed during LAPIP™ treatment. If removed, the crown will need to be completely replaced.

15. I am aware that I may receive an explanation of all risks and treatment (s) prior to starting, as well as responses to any other questions during the progress of my treatment, just by asking the doctor who is providing the LAPIP™ treatment. Risks, benefits, and alternatives for the LAPIP™ treatment have been explained, well as consequences of treatments, and non-treatment. All my questions have been answered.

16. If Dr._____ considers my case appropriate, I hereby give authorization for photos to be taken of my mouth during the course of the LAPIP™ treatment. It has been explained to me that these photos, videos, slides, or x-rays are limited to the purposes of diagnosis, treatment, education, and publication. These images will become part of my dental record and their use will be carefully controlled and executed in compliance will all state and federal regulations. All images will be stored in a secure manner that protects my privacy. It has further been explained to me that Dr. _____ has a duty to protect the confidentiality and integrity of private health information as required by law and professional ethics. When these images are used for education and/or publication purposes, it has been explained to me that identifying characteristics will be completely removed and the images will be rendered anonymous. The results of my treatment may be presented at meetings or in publications, however, my identity will not be disclosed in those presentations. By signing this agreement, I understand that patients have a fundamental right to autonomy (personal choice) over how their information is collected and used. I have the right to revoke my consent for photographing, videotaping, or making other images at any time.

17. With full understanding, I authorize Dr. _____ and the LAPIP™ treatment team to perform dental services for me, including LAPIP™ treatment 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. Dr. _____ has explained that if there is a need for someone to drive me from the doctor's 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 from the effects of the anesthesia or drug given me for my care, if it should be necessary.

18. I understand that Dr. _____ will do the very best according to all of the latest principles of laser dentistry to perform the LAPIP™ treatment on me. I understand that progress in LAPIP™ dentistry is continuous and due to that fact, I authorize any modification in design, material, or care to be performed on me - if based on my doctor's experience and professional judgment, he/she feels it is in my best interest.

19. I understand that it is necessary to complete all phases of recommended treatment, and I agree to do so.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

The LAPIP™ protocol uses the PerioLase® MVP-7™ dental laser.
US Patent # **#9,597,160**; International Patent Nos. **16865225.3 & 17744988.1**