Charles J. Burliss
DMD, MScD, PC

LANAP PROTOCOL CONSENT FORM

1. I have had a consultation with Dr. Burliss pertaining to my desire to treat my periodontal disease with the LANAP laser.
2. Dr. Burliss has explained other alternative periodontal surgical procedures and I hereby state that conventional (Widman Flap) and other methods of periodontal surgery are unsatisfactory for me.
3. I acknowledge that Dr. Burliss has explained that optimum results with LANAP 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 LANAP treatment.
4. Dr. Burliss has stated that smoking and alcohol can adversely affect gum tissue healing. I am aware that observations have shown that smoking and alcohol consumption may limit the longevity of the LANAP treatment.
5. I agree to comply with Dr. Burliss's detailed explanation of the procedure and understand that the importance of proper oral hygiene critical for optimal healing following LANAP treatment. I further agree to follow Dr. Burliss's diet recommendations in his post-op form.
6. Dr. Burliss has explained that if no treatment is undertaken, further gum and bone degeneration of the supporting tissues can continue increasing the severity and/or adding to my present periodontal condition.
7. Dr. Burliss has explained that it is my responsibility to keep my appointments for any further treatment as well as hygiene appointments at least once every three (3) months. I understand these visits are for the doctor to carefully check the status of my LANAP treatment.
8. 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.
9. I understand that LANAP 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, tissue shrinkage, recession of the gums, and exposure of roots surfaces—the exact duration of which may not be determinable. I understand that after adequate healing some areas may need to be spot treated with LANAP treatment and occlusal adjustments.
10. I understand that "severe" gum disease (Case Type III & IV) with "double digit" millimeter pocket measurements (e.g. 10 mm or more) will require "double" or a subsequent re-treatment , typically on a tooth-by-tooth basis but could involve the entire mouth as determined by the state of active disease. Treatment costs to be discussed in a treatment rendered basis.

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11. "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 are required as part of the protocol and the failure to complete all phases of occlusal adjustments and equilibration my result in oral/facial pain, temporal mandibular joint dysfunction (TMJ) sore and painful teeth. It has also been explained 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 can require the replacement of any and all crowns. I understand that occlusal adjustment is part of the LANAP treatment and is an ongoing part of my regular examination appointments.
12. I am aware 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 Dr. Burliss.
13. If Dr. Burliss considers my case appropriate, I hereby give authorization for photos to be taken of my mouth during the course of the LANAP treatment. It has been explained to me that these photos, videos, slides, or x-rays may be used in teaching other dentists for the advancement of LANAP protocol in dentistry.
14. With full understanding I authorize Dr. Burliss and the LANAP treatment team to perform dental services for me including anesthetic, sedation, and analgesia depending on the judgment of Dr. Burliss. Dr. Burliss has explained that if there is a need for someone to drive me from the 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.
15. I understand that Dr. Burliss will do the very best according to all of the latest principles of Laser dentistry to perform the LANAP treatment on me. I understand that progress in LANAP dentistry is continuous and due to that fact, I authorize any modification in design, material, or care to be performed on me based on Dr. Burliss's experience and professional judgment.
16. 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

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