Periodontics and Dental Implants

An explanation of your need for biopsy, its purpose and benefits, the surgery related to it and the possible complications as well as alternatives to its use were discussed with you at your consultation. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Consent for the performance of Biopsy on: _____

PURPOSE OF BIOPSY: I have been informed of the appearance of abnormal tissue in my mouth and that the proper evaluation of this tissue requires biopsy, this involving the removal of a portion or all of the abnormal tissue so that it can be examined histologically (microscopically) to ascertain the nature of the abnormality and/or to rule out the presence of serious disease.

DESCRIPTION OF THE PROCEDURE: The procedure will involve one of the following options:

1. **Remove the** entire **lesion**. If microscopic diagnosis is suspicious, it may be necessary to return to the area to remove additional tissues to obtain a margin of safety.
2. **Remove only enough tissue to get a good sample, leaving behind a portion of the lesion**. This is usually done when the lesion is believed to be benign, is very large, and/or the removal of the entire lesion at this time would be unnecessarily difficult. However, if the biopsy report is suspicious, the entire lesion may have to be removed later.

I consent to the performance of either alternative as may be deemed necessary in the best judgment of the treating doctor.

RISKS RELATED TO THE PROCEDURE: Risks related to biopsy might include, but are not limited to: allergic reactions, post-surgical infection, bleeding, swelling, pain, bruising, facial discoloration, , tooth sensitivity to hot, cold or sweets or acidic foods, shrinkage of the gum upon healing which could result in elongation of and/or greater spaces between some teeth, nerve injury causing transient but on occasion permanent numbness or tingling of adjacent facial or jaw areas, injury to the jaw joint and soreness of associated chewing muscles, injury to adjacent teeth during surgery, or scarring or other cosmetic changes. Rarely, there may be an opening into the sinus cavity in the upper jaw, possibly requiring additional treatment. Certain lesions may intimately involve sensory nerves, injury to which may cause pain, tingling or numbness in areas of the lips, chin, tongue, cheek, gums or teeth, or in areas of the skin of the face. Rarely, motor nerves may also be involved. If bone tissue is removed, healing may take longer, some complications may be more likely (for example, bleeding), and the biopsy report will take more time due to special processing requirements. There is always the possibility of the lesion recurring in the same area, even when it appears to be completely removed. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics. Any of the above may require additional medications or other care, possibly for a prolonged time.

ALTERNATIVES TO THE PROCEDURE: These may include:

1. No treatment, understanding that my condition may progress to adversely affect my health, especially as it relates to potential malignancy.
2. Observation of the lesion over a specific time period. If this choice is selected, it is important (perhaps live saving) that I assure complete cooperation by keeping follow-up appointments.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful. It is anticipated that the surgery will provide benefit in assessment of the abnormally appearing tissue; however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, the need for selective retreatment, or worsening of my present condition, despite the best of care.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include but are not limited to, extraction of hopeless teeth, the removal of a root or root fragment or foreign body associated with the biopsy site, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I also understand that I may be given appointments for long term follow-up care after my biopsy, even if the biopsy report is benign. I recognize the importance of such follow-up, which, if not done, may result in progression of my condition where additional care or surgery is required, or the lesion may recur and become a threat to my health. I agree to comply with regular exams as instructed and to promptly notify this office if I suspect a change in my condition.

SUPPLIMENTAL RECORDS AND THEIR USE: I consent to photography, video recording and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related biopsy as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

_____	_____	_____
Patient's Signature	Date	Patient's Name (please print)
_____	_____	_____
Signature of Patient's Guardian	Date	Relationship to Patient (please print)
_____	_____	
Signature of Witness	Date	