

Periodontics and Dental Implants

An explanation of your need for periodontal flap and osseous surgery for the purpose of crown lengthening, its purpose and benefits 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 Periodontal Flap and Osseous Surgery for the Purpose of Gaining Additional

Tooth Structure Exposure on #_____

PURPOSE OF CROWN LENGTHENING SURGERY: I have been informed that the purpose of this procedure is to increase the length of tooth exposed above the gum line so that the tooth can be properly restored with a filling or crown.

DESCRIPTION OF THE PROCEDURE: After anesthetics have numbed the area to be operated, the gum is reflected from about the teeth, the tooth or teeth requiring crown lengthening are cleaned and visualized. Usually, but not always, some reshaping of the jawbone surface adjacent to the roots of teeth may be performed to reduce bone height around the tooth or teeth requiring lengthening. If the gum tissue is thicker than normal, it may be reduced to gain crown lengthening. Finally, the gum flaps are replaced up against the teeth and sutured back around them.

RISKS RELATED TO THE PROCEDURE: Risks related to periodontal flap surgery and osseous surgery might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries, or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing or greater spaces between some teeth. In addition, the tooth, by nature of the cause for the crown lengthening procedure may also need a root canal filling and the rebuilding of lost tooth structure prior to proper restoration. 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.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) no treatment, with the expectation of the advancement of my condition resulting in the possible premature loss of teeth; (2) extraction of teeth with inadequate crown length; (3) attempts to restore the tooth or teeth with the anticipation of a less than adequate result, premature loss of the filling or crown and/or inflammation of the gum at the base of the filling or crown which can be associated with chronic tenderness, bleeding and weakening of the support of the tooth.

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 in providing a tooth that is capable of proper restoration by a filling or crown. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, 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 to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, 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 agree to report for appointments as needed following my surgery so that healing may be monitored, and the doctor can evaluate and report on the success of surgery.

SUPPLEMENTAL 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 to periodontal flap and osseous surgery 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

Signature of Patient's Guardian

Date

Relationship to Patient

Signature of Witness

Date