

Periodontics and Dental Implants

An explanation of your need for Guided Tissue Regeneration Surgery and possible complications as well as alternative to its use were discussed with you at your consultation. Please read this document which restate 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 Guided Tissue Regeneration Surgery to Gain New Gum Tissue Over an

Exposed Root on #: _____

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of significant gum recession about some of my teeth. I understand that it is important to have a sufficient width of gum (attached gingiva) around the base of the teeth (at the gumline) such that it maintains a seal of the gum to the teeth and thereby prevents bacterial invasion under the gum with subsequent inflammation. I understand that where there is insufficient attached gingiva (gum), bacteria and food can become lodged under the gumline and this may result in further recession of the gum or localized infection (gum abscess). I also understand that where there are fillings at the gumline or crowns (caps) with edges under the gumline, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or caps or the material from which they are made do not cause significant irritation to the gum.

PURPOSE OF GUIDED TISSUE REGENERATION OVER AN EXPOSED ROOT: I have been informed that the purpose of this procedure is to create an adequate zone (width) of attached gum tissue so as to prevent the likelihood of further gum recession and provide gum attachment - a seal against bacterial and food invasion. In addition, it can in some case result in the reduction of recession of the gumline about a tooth or teeth.

SUGGESTED TREATMENT: It has been suggested that this procedure be performed in areas of my mouth where I have significant gum recession. It has been explained that this is a surgical procedure involving the lifting of a flap of gum over the area of significant gum recession. Then, a membrane is placed inside a gumline flap (pouch) that has been created by releasing the edge of the gum from about a tooth or teeth. The gum flap and membrane are then sutured to secure them in place in such a manner that the new edge of the gum partially or completely covers the tooth root surface exposed by the recession. If the latter is attempted, I understand that the gum placed over the root may shrink back during healing and that the attempt to cover the exposed root surface may not be completely successful. I also understand that some membranes are made of materials that are naturally resorbed by the body and others are made of synthetic materials requiring the removal of the membrane several weeks or a few months after this surgery.

RISKS RELATED TO SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to guided tissue regeneration surgery might include, but are not limited to, post-operative bleeding, swelling, pain, infection, facial discoloration, allergic reaction to the membrane material, transient or, on occasion, permanent tooth sensitivity to hot or cold, sweets or acidic foods. Risks related to the local anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetics.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) connective tissue grafting where a piece of tissue is removed from under the surface of the gum in the roof of the mouth and transplanted to the area of gum recession, (2) the lateral movement of some gum from an adjacent tooth to attempt to gain new tissue over the exposed root (3) attempts to insulate teeth to control sensitivity by placing fillings in or on root surfaces with the expectation of further recession as a result of this procedure; (4) non-surgical scraping of tooth roots and lining of the gum (root planing and curettage) with the expectation that this will result in only a partial and temporary reduction of inflammation and infection, will not stop recession and will require more frequent professional care, and may result in the worsening of my condition and the premature loss of teeth; (5) no treatment, with the expectation of chronic inflammation resulting in the advancement of recession which is commonly associated with increased sensitivity of the teeth to temperature extremes and other irritants, increased risk of decay in root surfaces exposed by the recession and possibly the premature loss of teeth; (6) extraction of teeth involved with recession and a lack of attached gum tissue.

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 eradicating pockets, infection or further bone loss or gum recession. 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 utilization of another surgical design to attempt to attain the same result as described above 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 also understand that aerobic exercise may stimulate bleeding, the loss of a blood clot and have a negative effect on healing and the result of this 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 guided tissue regeneration surgery to gain new gum tissue over an exposed root 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 the Patient's Guardian

Date

Relationship to Patient

Signature of Witness

Date