

Periodontics and Dental Implants

An explanation of your need for Gingival Surgery and 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 Gingival Surgery

at site #: _____

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of abnormalities in gum about some of my teeth which are related to overgrowth of the gum or poor contour of the gum which make it harder for me to access areas where plaque accumulates and harder to perform professional scaling and cleaning of tartar from my teeth. I understand that the accumulation of plaque and tartar commonly result in gum inflammation which can be destructive to the tissues that support my teeth.

PURPOSE OF GINGIVAL SURGERY: I have been informed that the purpose of gingival surgery is to create a normal contour and height to my gums to facilitate access for the performance of personal and professional control of bacterial plaque and calculus (tartar).

SUGGESTED TREATMENT: It has been suggested that gingival surgery be performed in areas of my mouth where I have significant abnormalities in gum height and contour. It has been explained that this is a surgical procedure involving the removal of excess gum or the reshaping of the gum surface. This can either be accomplished by a reduction in the surface of the gum or by the reflection of gum flaps from around the teeth, their internal thinning and repositioning with suturing so as to produce a normal gum contour. After this, the operated areas are usually covered with a protective rubbery material - periodontal dressing - which is usually left on the operated areas for a week or more.

RISKS RELATED TO SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to gingival surgery might include, but are not limited to, post-operative bleeding, swelling, pain, infection, facial discoloration, 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) no treatment, with the expectation of chronic inflammation resulting in the advancement of gum overgrowth resulting in further difficulty with personal and professional hygiene procedures; (2) 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 change the problems with gum contour and overgrowth and will require more frequent professional care, and may result in the worsening of my condition and the premature loss of teeth.

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 normalizing the gum contour, or in preventing future infection or bone loss or gum overgrowth. It is anticipated that the surgery will provide benefit in reducing my condition and produce healing which will enhance access for the control of plaque and calculus (tartar). 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, use of flap or excisional methods including the possibly recontouring of bony understructure so as to facilitate better healing, or the 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 gingival 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