Osseous Surgery Consent

An explanation of your need for periodontal flap and osseous surgery, 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 that we discussed and please 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 on teeth

#: _____

PURPOSE FLAP AND OSSEOUS SURGERY: I have been informed that the purpose of this procedure is to allow access for the cleaning of the roots of teeth and the lining of gum as well as to treat irregularities of the jaw bone so that when the gum is replaced around the teeth, it will allow for the reduction of pockets, infection and inflammation, and so that the use of demineralized bone material might enhance bone healing. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and the ability of professionals to better clean my teeth of tartar and bacteria. This should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated area(s).

DESCRIPTION OF THE PROCEDURE: After anesthetics have numbed the area to be operated, the gum is reflected from around the tooth or teeth requiring surgery. The teeth and roots are cleaned and smoothed, antibiotics and other chemicals may be applied to the roots to decontaminate them. Some reshaping of the jawbone surface adjacent to the roots of teeth may be performed to reduce excessive bone or to recreate a more normal bone surface contour which may enhance the reduction of gum pockets on healing. If the gum tissue is thicker than normal, it may be reduced. 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 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. 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 involved with advanced bone loss; (3) attempts to further reduce bacteria and tartar under the gumline by surgical flap curettage (surgical root cleaning) with the expectation that this will not reduce pockets or strengthen weakened teeth (teeth with advanced bone loss); (4) non-surgical scraping of tooth roots and lining of the gum (root planing and curettage) with the expectation that this will not fully eliminate deep bacteria and tartar, result in only a partial and temporary reduction of inflammation and infection, will not reduce gum pockets 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 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, 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.

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 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.

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Patient's Signature Date Patient's Name

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Signature of Patient's Guardian Date Relationship to Patient

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Signature of Witness Date