

CONSENT TO PERIODONTAL SURGERY

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1. I am able to read and write in the English language.
2. I, _____, hereby authorize Dr. _____ to perform the following surgical procedure(s) as indicated below. A description of the procedures is on the reverse of this form.
 - A. Crown Lengthening Surgery
 - B. Mucogingival Surgery – Gingival Graft Surgery
 - C. Regenerative Surgery – Osseous grafts and/or Guided Tissue Regeneration
 - D. Replaced Flap Surgery
 - E. Other: _____
3. I understand that I have a form of periodontal disease or a periodontal condition that has caused damage to the soft tissues and/or bone around my teeth. This disease or condition, if left untreated, is generally non-reversible and can be progressive, eventually leading to further damage and possible loss of my teeth.
4. I also understand that a variety of surgical procedures are used to treat periodontal disease. While these surgical treatments are generally successful, I understand that no guarantee, warranty, or assurance has been given me that the proposed surgical treatment will be curative and/or successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present condition may result despite the treatment.
5. It has been explained to me that long term success of treatment requires my cooperation and performance of effective plaque control (home care) on a daily basis and periodic periodontal maintenance visits at a dental office after the proposed surgical treatment performed.
6. I further understand that if no treatment is rendered, my present periodontal condition has the potential to worsen with time and may result in premature tooth loss.
7. I have been informed that other possible alternative methods of treatment include scaling and root planning followed by periodic maintenance.
8. Although significant complications from periodontal surgery are rare, they can occur and may include the following:
 - A. Intrasurgical: bleeding, perforation of sinus membranes, nerve damage
 - B. Post-Surgical: bleeding, swelling, infection, discomfort, tooth sensitivity, tooth looseness, gum recession (shrinkage), numbness or altered sensation, exposure of crown margins, and/or _____.
9. I understand that this procedure may be photographed and/or recorded on video.
10. I certify that I have fully read and understand the above consent to the surgical treatment, the explanation therein referred to or made, and that all blanks were filled in or stricken before I signed this document.

PATIENT, PARENT, OR GUARDIAN

WITNESS

DATE

DOCTOR

Crown Lengthening Surgery: The purpose of this surgery is to expose more tooth to the oral cavity for the purpose of improved esthetics, improved cleansability, or to allow the restorative dentist to restore a badly broken down tooth. To accomplish this surgery, gum tissue and/or the bone around the teeth in question are reshaped by the surgeon.

Mucogingival Surgery: The purpose of this surgery is to improve the esthetics of the gums, cover exposed root surfaces, or to provide more suitable gum tissue around the teeth. To accomplish this procedure, gum tissue may be transplanted from one area of the mouth to another. The roof of the mouth is frequently used as the donor site and a protective plastic liner may be used to protect the area from where the donor tissue is taken.

Regenerative Surgery: The purpose of this procedure is to regenerate previously lost oral tissues such as bone, cementum, and/or periodontal ligament. To accomplish this procedure, materials such as bone grafts and membranes may be used. These materials may come from human or animal donor sources. The materials are taken under sterile conditions from donors with no known systemic diseases and blood tests that are negative for infection. The tissues are processed under sterile conditions, tested for bacterial contamination, and are stored in a vacuum-sealed sterile container. While transmission of infection of disease by an implanted biologic material can never be ruled out 100% of the time, these materials are considered to be extremely safe due to strict processing procedures. To date, no transmission of infection or disease has ever been documented with dental regenerative grafting materials.

Replaced Flap Surgery: The purpose of this procedure is to gain access to tooth and bone surfaces affected by periodontal disease. To accomplish this procedure, the gum tissue is reflected back allowing the surgeon to visualize the teeth and bone. The root surfaces are then thoroughly cleaned and the gum tissue is then replaced to its original position.

Other Surgical Procedures: The surgeon will describe the specifics of any procedure not covered in this consent form.