

Periodontics & Dental Implants

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PATIENT'S CONSENT FOR PERIODONTAL FLAP SURGERY &/OR CROWN LENGTHENING

DIAGNOSIS: I have been informed of the presence of periodontal disease in my mouth and that this involves the weakening of support to my teeth by first producing a separation of the gum from the teeth (pockets). This allows for the greater accumulation of bacteria under the gum in hard to clean areas and that this can result in my body's defense reactions or infection resulting in the erosion or loss of bone supporting the roots of my teeth.

PURPOSE OF PERIODONTAL FLAP SURGERY: I have been informed that the purpose of this procedure is to allow for the cleaning of the roots of teeth and the lining of the gum as well as to treat irregularities to the jaw bone surface so that when the gum is replaced about the teeth, it will allow for the reduction of pockets, infection and inflammation. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and of the ability of professionals to better clean my teeth of tartar and bacteria which are the primary cause of periodontal disease. The reduction of infection and inflammation should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated area (s).

ALTERNATIVES TO THE SUGGESTED TREATMENT: 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 periodontal disease; 3) Attempts to further reduce bacteria and tartar under the gum line by 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, thus resulting in only a partial and temporary reduction of inflammation and infection. These alternatives 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.

RISKS RELATED TO THE SUGGESTED TREATMENT: Risks related to periodontal flap 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 resulting in elongation of some teeth and 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 or bruising, pain, soreness or discoloration at the site of injection of the anesthesia.

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, infections or further bone loss or recession. It is anticipated (hoped) 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 but due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risks of failure, relapse, selective re-treatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement despite the best of care.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which 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, the placement of a bone graft material to guide (enhance) tissue regeneration or termination of the procedure prior to completion of all of the surgery originally outlined. 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 my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

NITROUS OXIDE (optional): Nitrous oxide/Oxygen inhalation is a mild form of conscious sedation used to calm an anxious patient. A colorless, odorless gas that has no explosive or flammable properties, it can act as a pain buffer as well. Oxygen is given simultaneously with the Nitrous Oxide through a small mask placed over the nose. Pure Oxygen, given at the end of treatment, is intended to flush the Nitrous out of the patient's system and minimize the effects of the gas. The patient remains awake and can respond to directions and questions. Nitrous Oxide helps overcome apprehension, anxiety, or fear. Nitrous risks include but are not limited to: Inability to perceive one's spatial orientation and temporary numbness and tingling. Nausea and vomiting may occur. If the patient will not accept the mask, Nitrous Oxide/Oxygen cannot be used.

DESCRIPTION OF GRAFT MATERIAL: If bone graft (s) are recommended demineralized bone Allografts will be used. Our first choice is a freeze - dried mineral matrix produced by removal of all organic components from Bovine bone . If refused per patient we could use demineralized freeze - dried human bone or synthetic bone . We also use a collagen membrane extracted from veterinary certified pigs which is carefully purified to avoid antigenic reactions to cover the bone material. If refused by patient we could use synthetic membranes . Please check materials desired.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to periodontal flap surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

- I have read and fully understood the terms within this document and consent to the surgical periodontal treatment (s) as described above.
- I have read and fully understood the terms within this document and refuse to give my consent for the proposed treatment plan as described above. I have also been informed of and accept the consequences if no treatment is administered.

Patient's Signature (or guardian if patient is a minor) Print Name Date

Signature of Witness Print Name Date