Periodontics & Dental Implants
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PATIENT'S CONSENT FOR GINGIVAL GRAFT SURGERY

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of significant gum recession in my mouth. I understand that it is important to have sufficient width of gum (attached gingiva) around the base of the teeth (at the gum line) to minimize the probability of food particles and bacteria lodging between the gum and the teeth. I understand that where there is insufficient attached gingiva (gum) and food or bacteria become lodged under the gum line, this may result in further recession of the gum or in a localized infection (gum abscess.) I also understand that where there are fillings at the gum line or crowns (caps) with edges under the gum line, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or caps of the material from which they are made do not cause significant irritation to the gum.

PURPOSE OF GINGIVAL GRAFTING: I have been informed that the purpose of gingival (gum) grafting is to create an adequate band (width) of attached gum tissue so as to prevent the likelihood of further gum recession.

SUGGESTED TREATMENT: It has been suggested that gingival grafting 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 removal of a thin strip of gum from the roof of my mouth, alongside the upper teeth or the use of donated tissue (Alloderm – see description of graft material) and transplanting it to the area of significant gum recession. There it can be placed at the base of the remaining gum or it can be placed so as to partially cover the tooth root surface exposed by the recession. If the later 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.

DESCRIPTION OF GRAFT MATERIAL: Alloderm is freezed dried human skin donated from cadavers. All donors are screened and tested to prevent the transmission of disease to the person receiving the graft. Alloderm is processed to remove all cells and does not contain living cells. It provides the collagen structure and proteins that help your body's own tissue regrow.

RISKS RELATED TO THE SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to gingival grafting might include post-operative bleeding, swelling, pain, infection, facial discoloration, transient or on occasion permanent tooth sensitivity to hot, 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, bruising, pain, soreness, and discoloration at the site of injections of the anesthetics.

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 by reducing the likelihood of further gum recession in the treated area(s), 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.

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 additional teeth requiring gingival grafts, 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 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.

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 gingival graft 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 consequence if no treatment is administered.

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