OC DENTAL SPECIALTY GROUP

CONSENT FOR GINGIVAL AUGMENTATION SURGERY

In order to treat the gum recession in my mouth it has been recommended that I have a gingival augmentation procedure performed. I understand that a local anesthetic will be administered to me as part of the treatment.

The purpose of gingival augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. An additional purpose for this procedure may be to cover exposed root surfaces by increasing the width of existing attached gum tissue, thus enhancing the appearance of the teeth.

This surgical procedure involves transplanting a thin strip of gum tissue from the roof of my mouth or from adjacent teeth to the area of recession. An alternative technique involves the placement of a restorable membrane under the gum in the area of recession.

Post- operative risks of the proposed surgery include the possibility of swelling pain, restricted opening of the mouth for several days and increased tooth sensitivity to hot, cold, sweet or acidic foods for a period of time.

I understand that a small number of patients do not respond successfully and completely to gingival augmentation, resulting in a portion of the root surface remaining exposed. The success of gingival augmentation can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene and medications I may be taking.

I hereby acknowledge that neither guarantee nor assurance as to the success of the treatment has been stated or implied.

I certify that I have thoroughly read this document and understand its contents. I have had an opportunity to discuss with the doctor any concerns I have regarding the proposed treatment and hereby consent to the gingival augmentation surgery as presented to me.

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Date Printed Name of Patient

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Patient Signature