CONSENT TO PERIODONTAL (GUM) SURGERY

In order to treat periodontal disease in my mouth it has been recommended that periodontal surgery be done. I understand that the purpose of this surgery is to reduce the gum inflammation and the periodontal pockets (space between the gum and tooth) in order to stop the bone resorption process in my mouth, and in selected instances to restore lost bone to the extent possible.

During this procedure bone irregularities around the teeth may be reshaped or bone graft material may be placed in the defects. This material may include my own bone from an adjacent site, synthetic bone substitutes, or bone obtained from tissue banks. A thin, covering membrane may also be placed over the bone defect (with or without graft material) to enhance the regenerative process.

I understand that I will be receiving a local anesthetic as part of the treatment and the doctor may prescribe both analgesics (pain pills) and antibiotics afterwards.

Post-operative risks of the proposed surgery include the possibility of swelling, pain and infection in the surgical site; restricted opening of the mouth for several days; transient facial discoloration; increased tooth sensitivity to hot, cold, and sweets which may persist for some time. There may be a temporary increase in mobility (looseness) of some teeth, gum recession showing more of the tooth root with possible exposure of existing crown (cap) margins, and enlarged spaces in between some teeth. These spaces could cause a temporary alteration of certain speech sounds and cause food particles to collect requiring the use of special oral hygiene devices (floss, Water- Pik, small interdental brush,etc.) to remove them.

I understand the alternatives to periodontal surgery include: no treatment- with expectation of a worsening condition and premature tooth loss; extraction of the more severely involved teeth; continued non-surgical scraping o the tooth roots and lining of the gums (scaling and root planning) with or without antibiotic medication, with likelihood that this treatment will not fully eliminate the deep bacteria and tartar, may not reduce the gum pockets significantly, and may result in the worsening of the disease and tooth loss.

I acknowledge that neither guarantee nor assurance as to the success of the treatment has been stated or implied. Due to individual patient differences there exists a risk of failure, relapse, or need for selective re- treatment despite the best of care. However, in most cases therapy will be effective in restoring the health of the periodontal tissues and therapy retaining teeth.

Both short and long term success can be affected by the patient’s medical condition, dietary and nutritional problems, smoking, excessive alcohol consumption, clenching and grinding of the teeth, stress and, most definitely, inadequate oral hygiene.

I understand that my daily oral hygiene program to control the bacterial plaque levels in my mouth combined with periodic office visits for periodontal maintenance and monitoring will pay an integral part in determining the long term success of the surgical treatment.

I certify that I have thoroughly read this document and understand its contents. I have had the opportunity to discuss with the doctor any concerns I have regarding the proposed treatment and hereby consent to the recommended periodontal surgery.

_____ _____

PRINTED NAME OF PATIENT DATE

_____ _____

PATIENT SIGNATURE WITNESS