

CONSENT FOR GINGIVAL GRAFT SURGERY FOR

Please read this document, which repeats issues we discussed in their entirety and provide the appropriate signatures on the last page. Please excuse us for this inconvenience and do ask to clarify anything that you do not understand.

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 a sufficient width of gum (attached gingiva) around the base of the teeth (at the gum line) such that it minimizes 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 gumline, 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 gumline or crowns (caps) with edges under the gumline, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or caps, or the materials 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 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 latter is attempted, I understand that the gum placed over the root may shrink during healing and that the attempt to cover the exposed root surface may not be completely successful.

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, but on occasion permanent, numbness of the lip, tongue, teeth, chin or gums; transient, but on occasion permanent, sensitivity to hot, cold, sweet, or acidic foods. 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 the injection of the anesthetics.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee or warranty has been given to me that the proposed surgery will be completely successful in eradicating pockets, infections or further bone loss or gum recession. It is anticipated 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). However, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective re-treatment or worsening of my present condition.

SEDATION: I have been advised that oral sedative drugs and/or nitrous oxide inhalation sedation may be administered during surgery. I therefore agree that I will not drive before or after surgery and will make arrangements to be driven and accompanied home. I also agree to follow the pre-surgical

and post-surgical instructions given to me.

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 my surgery upon completion of healing.

SUPPLEMENTAL RECORDS & THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures, as related to these procedures and for their educational use in lectures or publications, provided my identity is not revealed.

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.

Date

_____ of _____
Relationship to Patient Patient's Name

Signature of Witness Date

As part of this consent agreement, I give my personal pledge, as a healthcare professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.

Signature of Doctor Provines Date

REV: 02/08

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