

PATIENT'S CONSENT FOR PERIODONTAL SURGERY FOR

An explanation of your need for periodontal surgery, the procedure and post-operative care, its purpose, benefits, possible complications, as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo the treatment planned for you. 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 periodontal disease in my mouth and that this involves the weakening of the 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 erosion of loss of bone supporting the roots of my teeth.

SUGGESTED TREATMENT: It has been suggested that my treatment include periodontal flap surgery.

PURPOSE OF PERIODONTAL FLAP SURGERY: I have been informed that the purpose of this procedure is to allow access 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. 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 gumline by non-surgical scraping of the tooth roots and lining of the gum (root planing and curettage) with the expectation that this will not fully eliminate deep bacteria and tartar, result in only a partial and temporary reduction of inflammation and infection, will not reduce gum pockets and will require more frequent professional care and may result in the worsening of my condition and 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 gums, jaw joint injuries or associated muscle spasm, transient, but on occasion permanent, increased tooth looseness, tooth sensitivity to hot, cold, sweet, 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 the injection of the anesthetics.

If you are taking a type of drug called a bisphosphonate, you may be at risk for developing osteonecrosis of the jaw and certain dental treatments may increase that risk.

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 (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 risk 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.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for modification or change from the anticipated surgical plan. These may include, but are not limited to, extractions 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 or the use of 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 judgement of the treating doctor.

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 periodontal flap 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

_____ Date: _____
Signature of Witness

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.

_____ Date: _____
Signature of Doctor Provines

Peninsula Center for Implantology