

CONSENT FOR PERIODONTAL SURGERY FOR

SUGGESTED TREATMENT: It has been suggested that my treatment includes extraction of my wisdom teeth.

RISKS RELATED TO THE SUGGESTED TREATMENT: Risks related to extraction 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. 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 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. I, therefore, consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgement of Doctor Provines.

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 to and from the office on the day of surgery.

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.

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 the periodontal surgery as presented to me during consultation and treatment plan presentation by Dr. Provines or as described in this document.

signature

Date

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 _____ receives the best possible care with the least possible risk.

Joe A. Provines, D.M.D.

Signature of Doctor Provines

REV. 1/2009

Date

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