Consent for Tissue Grafting Surgery

Patient Name: ______________________________

This consent for treatment is given to the attending doctor after having first been fully informed of the diagnosis, the proposed treatment, treatment alternatives and risks.

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that I have significant gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gumline or crowns with edges under the gumline, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

Recommended Treatment: In order to treat this condition, my periodontist has recommended that gum grafting procedures be performed in areas of my mouth with significant gum recession. I understand that a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplanting of a thin strip of gum from elsewhere in my mouth. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed so as to completely or partially cover the tooth suface exposed by recession. Stitches will be used and a periodontal bandage or dressing may be placed.

Expected Benefits: The purpose of the gum grafting is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, or to prevent or treat root sensitivity or root decay.

Principal Risks and Complications: I understand that some patients do not respond successfully to gum grafting. If a transplant is placed so as to cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during the healing. In such case, the attempt to cover the exposed root surface may not be completely successful.

I understand that complications may result from gum grafting or from anesthetics. The complications include, but are not limited to (1) post-surgical infection, (2) bleeding, swelling and pain, (3) facial discoloration, (4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet, or acidic foods, (5) allergic reactions, and (6) accidental swallowing of a foreign matter. The exact duration of any complications cannot be determined and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of gum grafting can be affected by (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) alcohol consumption, (5) clenching and grinding of the teeth, (6) inadequate oral hygiene, and (7) medications that I may be taking. To my knowledge I have reported to my periodontist my prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist, and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives To Suggested Treatment. My periodontist has explained alternative treatments for gum recession, and modification of technique for brushing my teeth.

Necessary Follow-up Care and Self-Care I understand that it is important for me to continue to see my regular dentist. Existing restorative therapy can be an important factor in the success or failure of gum grafting.

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following the surgery so that healing may be monitored and so that the periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to abide by the specific prescriptions and instructions given by my periodontist.

No Warranty or Guarantee. I hereby acknowledge that no guarantee, warranty, or assurance had been given to me that the proposed treatment will be successful. In most cases, treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict the absolute certainty of success. There is risk of failure, relapse, and additional treatment or worsening of my present condition.

Use of Records for Reimbursement Purposes I authorize photos, slides, x-rays, or other viewings of my care and treatment during or after its completion to be used for reimbursement purposes.

PATIENT CONSENT

I have been fully informed of the nature of gum grafting surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of gum grafting surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional and alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATION THAT I AM ABOUT TO SIGN FOR THE PROPOSED TREATMENT DESCRIBED ABOVE. I ACCEPT THE RISKS OF HARM IN HOPES OF OBTAINING THE DESIRED BENEFICIAL RESULTS OF THIS TREATMENT.

Patient Signature ____ Date __________________________

Legal Guardian (if patient is under 18 years of age) ____

Signature of attending doctor ____

Signature of Witness ____

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