

## CONSENT FOR PERIODONTAL SURGERY

READ,  
SIGN &  
RETURN

***Diagnosis.*** After a careful oral examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further erosion or loss of bone and gum supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health.

***Recommended Treatment.*** In order to treat this condition, my periodontist has recommended that my treatment include periodontal surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

During this procedure, my gum will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped, and bone regenerative material may be placed around my teeth. My gum will then be sutured back into position, and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to: (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

***Expected Benefits.*** The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

***Principal Risks And Complications.*** I understand that a small number of patients do not respond successfully to periodontal surgery and, in such cases, the involved teeth may eventually be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip tongue, teeth, chin or gum, 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, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or

weeks, impact on speech, allergic reactions, and accidental swallowing of 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 and bone will heal. I understand that there may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any 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.*** I understand that alternatives to periodontal surgery include: no treatment – with the expectation of possible advancement of my condition which may result in premature loss of teeth; extraction of teeth involved with periodontal disease; and non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medication, in an attempt further to reduce bacteria and tartar under the gumline – with the expectation that this may not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care and time commitment, and may not arrest the worsening of my condition and the premature loss of 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 dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my periodontist may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the extraction of one or more teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

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 my surgery so that my healing may be monitored and so that my 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: (1) abide by the specific prescriptions and instructions given by the periodontist, and (2) see my periodontist and dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

***No Warranty Or Guarantee.*** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the 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 certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

***Publication Of Records.*** I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of periodontology

and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

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## PATIENT CONSENT

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal 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 periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Date: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name of Patient, Parent or Guardian)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Signature of Patient, Parent or Guardian)

\_\_\_\_\_  
(Signature of Witness)