Provider: Dr Ash

CONSENT FOR GINGIVAL AUGMENTATION SURGERY

Patient's Name Date

During your consultation we discussed your need for bone gingival augmentation surgery, steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure**. Please initial each paragraph after reading, if you have any questions please ask your periodontist before initialing and signing on the last page.**

_____***1. 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. Gingival augmentation may also be performed to improve appearance, reduce sensitivity and/or to protect roots of the teeth from caries. I understand that root coverage with the assistance of soft tissue grafting depends on the bony architecture. The bony architecture dictates the extent to which recession or root exposure can be covered after healing is complete.

_____***2. Recommended Treatment.*** In order to treat my condition, my periodontist has recommended that gingival augmentation (gum
grafting) procedures be performed in areas of my mouth with significant gum recession. I understand that sedation may be utilized and 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 or from other sources such as human cadaver (Alloderm) or porcine (pig). All donors are screened by physicians and other health care workers to prevent the transmission of disease to the person receiving the graft. They are tested of hepatitis, syphilis, blood and tissue infections, and the AIDS virus. Tissue is recovered and processed under sterile conditions. The transplanted strip of gum 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. Biologic materials to aid in soft tissue regeneration may also be used in combination with gum grafting. A periodontal dressing may be placed at the end of the procedure.

_____***3. Expected Benefits.*** The purpose of gingival augmentation 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 gumline, or to prevent or treat root sensitivity or root decay.

_____***4. Principal Risks and Complications.***
I understand that a small number of patients do not respond successfully to gingival augmentation surgery. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession with increased spacing between the teeth.

I understand that other complications may result from gingival augmentation or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, and accidental swallowing of foreign matter. Local anesthetic injection may cause allergic reaction, temporary or permanent injury to nerves and/or blood vessels. During surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function. This can lead to transient (usually this disappears slowly over several weeks or months) but on occasion permanent numbness, itching, burning, pain or tingling of the jaw, teeth, gums, tongue (including the possibility of loss of taste sensation), lip, chin, cheek, or in areas of the skin of the face.

There is no method that will accurately predict or evaluate how the gum and bone will heal before the surgery is done. I understand that there may be a need for a second surgery 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 (including over-the-counter medications such as aspirin, nutritional supplements and herbs that I may be taking). To my knowledge, I have reported to my doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that might in any way relate to this surgical procedure. I have also told my doctor about any present or prior head and neck radiation therapy and present or prior

use of bisphosphonate (for osteoprosis) medications. Some common brand names are Zometa, Aredia, Boniva, Fosamax, and Actonel.

_____***5. Alternatives to Suggested Treatment.*** Alternative treatment to gum grafting surgery include: No treatment, continued monitoring
for progressive recession, and modification of technique for brushing my teeth.

_____***6. 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 gingival augmentation. I recognize that natural teeth and appliances 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 competition 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
(1) to abide by the specific prescriptions and instructions given by my periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment. Maintenance may also include adjustment of prosthetic appliances.

_____ 7. Unforeseen Conditions. During the surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best professional judgment of my periodontist.

_____8. No Warranty or Guarantee. 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 worsening of my present condition, including the possible loss of certain teeth, despite the best care.

_____9. Use of Records for Reimbursement and Publication Purposes. I authorize photos, video recordings, x-rays, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry, educational use in lectures or publications and reimbursement purposes. My identity will never be revealed to the general public.

_____10. Females only. Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the gingival augmentation surgery, the alternative treatments available, and the necessity for follow-up care 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 gingival augmentation surgery as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document

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Patient's Signature (or patient's guardian) Date

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Witness Signature Date