

Provider: Dr Ash

CONSENT FOR PERIODONTAL SURGERY

Patient's Name

Date

During your consultation we discussed your need for periodontal surgery, the 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 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.

_____ **2. Recommended Treatment.** To treat my condition, my periodontist has recommended that my treatment may include conventional periodontal surgery. During this procedure, instruments and devices (rotary, laser) may be used to remove the inflamed and infected gum tissue and allow for better access to the root surfaces so that they may be thoroughly cleaned with ultrasonic scalers (ultrasonic scalers may adversely affect how a cardiac pacemaker functions) and hand scalers. In some cases, the gums may be opened to permit better access to the roots and to the eroded bone. Bone irregularities may be reshaped. I further understand that antibiotics, bone graft material, and biologic substances may be applied to the roots of my teeth and the surrounding bone defect to enhance healing/regeneration. I also understand that sedation may be utilized and a local anesthetic will be administered as part of the treatment. One or more of the following bone graft materials maybe used: Allograft (processed human bone powder), Bovine (cow) and Artificial bone-like ceramic or mineral substances. A membrane/barrier may be used with or without bone graft material. My gums may be sutured back into position over the above materials, and a periodontal bandage or dressing may be placed. The periodontal procedure requires occlusal (bite) adjustments and equilibration, which has been explained to me in detail. I understand that occlusal adjustment is a fundamental part of conventional periodontal surgery's successful outcome and is an ongoing part of my regular examination appointments. I further understand that wearing an occlusal guard may also be recommended. The use of antibiotics and anti-microbial rinses is also a crucial part of the procedure and must be taken as prescribed.

_____ **3. Expected Benefits.** The purpose of conventional periodontal surgery is to reduce pockets, infection, inflammation, and to restore my gum and bone to the extent possible. Increased gum pockets and inflammation have been shown in studies to contribute to health problems such as heart disease, stroke, respiratory diseases and pre-term childbirths. Studies also indicate that the rate of periodontal deterioration may be significantly increased in periodontal patients who also have diabetes. In diabetic patients, not only are they more prone to gum disease, but the gum disease itself may also make it more difficult for them to control their blood sugar levels.

The conventional periodontal surgery is further 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. The use of conventional periodontal surgery, bone graft material, biologics or the placement of a membrane is intended to regenerate some of the lost bone to enhance bone and gum healing.

_____ **4. Principal Risks and Complications.** I understand that a small number of patients do not respond successfully to conventional periodontal surgery with bone regenerative procedures. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not be possible. In rare cases, the involved teeth may ultimately be lost. I further understand adjusting my crowns can remove porcelain, expose metal and/or tooth structure, and may require root canal therapy and/or the replacement of any or all crowns.

I understand that complications may result from periodontal surgery, drugs or anesthetics administered. 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, and accidental swallowing of foreign matter. The bone graft material may fail to integrate with natural bone resulting in failure of the graft. Additional bone grafting may be necessary to obtain sufficient bone volume. The chance of viral or bacterial disease transmission from processed (Non-Autogenous) bone is always a very remote possibility (very rare). Biologic/synthetic membranes are often used to contain and protect the graft. Some may require a second procedure to remove them; or some may be unexpectedly lost in which case the graft may be adversely affected. Allergic reactions (previously

unknown) may possibly occur to any medications used in grafting procedures. 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 second procedure if the initial surgery is not entirely successful. 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 my medications as prescribed are important to the ultimate success of the procedure.

_____ **5. Alternatives to Suggested Treatment.** I understand that alternatives to conventional periodontal surgery with bone regenerative surgery include: (1) no treatment—with the expectation of possible advancement of my condition which may result in premature loss of teeth, (2) extraction of teeth involved with periodontal disease, (3) 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 tarter under the gum line—with the expectation that this may not fully eliminate deep bacteria and tarter, 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.

_____ **6. Necessary Follow-up and Self-care.** I understand that it is important for me to continue to see my general dentist. Existing restorative dentistry can be an important factor in the success of 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 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 (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

_____ **7. Unforeseen Conditions.** 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) 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 professional judgment of my periodontist.

_____ **8. 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 worsening of my present condition, including the possible loss of certain teeth, despite the best care. I understand that “severe” gum disease with “double digit” millimeter pocket measurements (e.g. 10mm or more) may require a subsequent re-treatment at the same fee as the first, typically on a tooth-by-tooth basis, but could involve the entire mouth as determined by the state of active disease.

_____ **9. Publication of Records.** I authorize photos, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

_____ **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 conventional periodontal 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 about the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the periodontal 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 etc. I certify that I have read and fully understand this document.

Patient’s Signature (or patient’s guardian)

Date

Witness Signature

Date