INFORMED CONSENT FOR GINGIVAL AUGMENTATION SURGERY

I hereby authorize Dr. _____ (herein called Doctor) to perform gingival augmentation surgery on myself.

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

Recommended Treatment: In order to treat this condition, my Doctor has recommended that gingival augmentation procedures be performed in areas of my mouth with gum recession. A local anesthetic will be administered in addition to medications deemed appropriate by my Doctor. This surgical procedure involves the transplanting of a thin strip of gum from the root of my mouth or from the adjacent teeth. The transplanted strip of gum can b placed at the base of the remaining gum, or it can be placed as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

An alternative technique consists of the placement of a bone regenerative material (human bone obtained from a tissue bank) and a non-restorable membrane on the root surface. In that case, the membrane requires a small surgical procedure after about six weeks to remove the membrane.

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 of this procedure may be to cover exposed root surfaces, to enhance the appearance of teeth and gum line, or to prevent or treat root sensitivity or root decay.

Principal Risks and Complications: Some patients do not respond successfully to gingival augmentation. 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 root surface may not be completely successful. In some cases, it may result in more recession with increased spacing between the teeth. I understand that unforeseen changes may lead to a change in my dental treatment plan. This may include, but is not limited to: (1) the need for additional dental work, or (2) modification of the planned dental work.

I understand that complications may result from the surgery and/or any drugs used. These complications may include, but are not limited to, infection; bleeding; swelling; pain; temporary discoloration of my face; 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. Allergic reactions and accidental swallowing or inhaling of foreign matter are also possible. The duration of complications can not be determined, and complications may be irreversible.

No method can accurately predict or evaluate how my gum and bone will heal. There may be a need for a second procedure if the initial results are not satisfactory. The success of gingival augmentation 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 Doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which I have no or have had at any time in the past.

Alternatives to Suggested Treatment: My periodontist has explained alternative treatments for my gum recession. These include no treatment; continued monitoring for progressive recession; and modification of technique for brushing my teeth. Principal risk with an of these alternatives includes continued recession with further exposure of the root and possible tooth loss.

Necessary Follow-Up and Self-Care: It is important for me to: (1) abide by the specific prescriptions and instructions given by my Doctor, and (2) see my Doctor and my regular dentist for periodic examinations and preventative treatment. Failure to follow such recommendations could lead to ill effects and treatment failure. Adequate daily oral hygiene performed with a non-traumatic method of brushing my teeth is essential for the success of the procedure. Although my Doctor informs me when the next periodic visit is needed, I am responsible for contacting the Doctor's office o make appropriate appointments.

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. However, there is a risk of failure, relapse, additional treatment, or worsening of my present condition resulting in the loss of my teeth despite the best of case.

Publication of Records: I authorize that my dental records, slides, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

I have read this entire form and understand everything explained in it. I have had the opportunity to ask the doctor about any questions I may have about the treatment, the risks of surgery, the alternative treatment methods and the substantial risks of the alternative treatment methods. The Doctor has answered all my questions. I authorize the doctor and whomever they may choose as their assistants to perform the proposed periodontal surgery.

Signature of Patient _____ Date _____

Signature of Dental Specialist _____ Date _____