PROSTHODONTIC ASSOCIATES

INFORMED CONSENT FOR SOFT TISSUE GRAFTING

GINGIVAL (GUM) GRAFTING

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 teeth and gum line, or to prevent or treat root sensitivity or root decay.

Principle Risks and Complications
I understand that my own gum tissue provides the most predictable result; however other options are available to me such as donor tissue should I choose not to use my own gum tissue. These substitutes are safe and generally associated with good results.

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 or with increased spacing between the teeth.

The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long- term success may not occur. In rare cases the involved teeth may ultimately be lost.

I understand that complications may result from grafting surgery, drugs, or local anesthetics. The exact duration of any complications cannot be determined and they may be irreversible. These complications include but are not limited to:

Pain; swelling; bruising; infection; bleeding; injury to neighboring or adjacent teeth; adverse drug reactions; discomfort; temporary or permanent damage to the nerves that give sensation to the area of the palate from which the graft is harvested which could result in numbness, tingling, burning, or pain of the affected area.

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 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 Dr. Bhide any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that I have. I understand that my diligence in providing the personal daily care recommended by Dr. Bhide and taking all prescribed medications are important to the ultimate success of the procedure.

Necessary Follow-up Care And Self-Care
I recognize that natural teeth 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 Dr. Bhide 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 Dr. Bhide and (2) to see my general dentist for periodic examination and preventative treatment.

Costs
The estimated cost for this procedure has been provided to me during the initial consultation visit.

I have been fully informed of the surgery to be performed. Dr. Bhide has explained that evidence indicates the procedure is needed to maintain a healthy periodontal condition. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self care. I realize that during the course of the surgery, the treatment may need to be modified due to existing conditions that are only evident when the surgical site has been exposed.

I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Bhide.
By signing below, I hereby consent to the performance of gum grafting surgery as presented to me and consent to any additional or alternative procedures that may be deemed necessary in the judgment of Dr. Bhide. I agree to be ultimately responsible for payment of the treatment.

Patient Signature _____ Date _____

Signature of Dental Specialist _____

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