Discussion and Informed Consent for Surgical Periodontal (gums and bone) Treatment

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment & Site(s): _____

Facts for Consideration

Patient's initials required where applicable

_____ Surgical periodontal therapy may involve several different procedures for removing inflamed or infected gum tissue as well as cleaning and/or restoring gum tissue or bone damaged by periodontal (gum) disease. An examination of your oral cavity measures the pockets under the gums surrounding your teeth to determine which periodontal treatment(s) your gum condition requires. Dental X-rays will be taken to check the condition of the bone that supports your teeth.

_____ One type of surgical treatment, ***gingivectomy***, is the surgical removal of all loose, infected and diseased gingival (gum) tissue to remove periodontal infection and reduce the depth of the space between the tooth and the gum tissue that surrounds the tooth. Sedation or premedication may be recommended and prescribed for you prior to the surgery.

_____ Treatment may also include ***flap/osseous (bone) surgery***: These procedures involve cutting and lifting up a small area of the gum to expose the bony defect around the tooth. The affected tissue may be cleaned out, the bone recontoured (reshaped) and/or real or synthetic bone material may be grafted into the site. A protective membrane (barrier or cover) may also be inserted and sutured into place and a periodontal dressing (special adhesive bandage) may be placed over the area of the surgery.

_____ ***Crown lengthening*** is a type of surgery designed to expose more tooth structure to provide greater retention (hold) for a crown. It involves all the components of osseous surgery. Typically, the crown may be placed approximately four to six weeks after such surgery.

_____ A ***gingival (gum) graft*** involves moving gum tissue from one site to another. Typically, this is done to cover an exposed root or to provide a zone of attached gingiva around a tooth where the normal tissue has receded. The graft may be harvested from the roof of your mouth or, alternatively, tissue from a tissue bank may be utilized. The primary goal is to increase the attached tissue (gingiva), which creates a seal around the tooth and helps protect the underlying tooth, bone and gums (gingiva).

_____ The success of the treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow proper home care.

_____ A local anesthetic (numbing medication) may be administered depending on the location and depth of the area.

Benefits of Surgical Periodontal Treatment, Not Limited to the Following:

_____ Surgical periodontal treatment can help to create a cleaner environment in which your gums can heal, help to reduce the chances of further gum irritation or infection, make it easier for you to keep your teeth clean, improve your chances of retaining teeth and their function and decrease your costs, which would incur when you must replace teeth lost due to gum disease. This course of treatment may help to improve your condition and prevent this disease from spreading.

Risks of Surgical Periodontal Treatment, Not Limited to the Following:

_____ As a risk or result of surgery, I understand that my gums may bleed or swell and I may experience moderate discomfort for several hours after the anesthesia wears off. There may be slight soreness for a few days, which may be treated with pain medication. I will notify the office if such conditions persist beyond a few days.

_____ I understand that because cleanings and surgery involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which may be treated with antibiotics. I will immediately contact the office if I experience fever, chills, sweats or numbness.

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problems. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____ I understand that as my gum tissue heals after treatment or surgery, it may shrink somewhat, exposing some of the root surface of the teeth. This could make teeth more sensitive to hot or cold. I also understand that following treatment, I may have spaces between my teeth at the gum line that could trap food particles and require special maintenance. I understand additional surgical procedures may be needed to protect the sensitive areas.

_____ I understand that depending on my current dental condition, existing medical problems or medications I may be taking, these treatment methods alone may not completely reverse the effects of gum disease or prevent further problems. Teeth that become loose as a result of periodontal disease may need to be extracted, which would involve replacing the lost teeth with a fixed or removable bridge, denture or artificial teeth called implants.

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

_____ I understand that smoking may significantly interfere with healing and may limit the successful outcome of my treatment.

_____ I understand that at the initiation of and during treatment I may receive a topical or local anesthetic and/or other medication. In rare instances, patients may have a reaction to the anesthetic, which could require emergency medical attention. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** In rare cases, temporary or permanent nerve injury, numbness of the lip, chin, gums, teeth, cheek and/or tongue can result from an injection.

_____ I am_____/I am not_____currently or in the past taken bisphosphonates for the purpose of treating osteoporosis.

_____ I understand that while every reasonable effort will be made to ensure that my condition is treated, it is not possible to guarantee perfect results. By signing below, I acknowledge that I have received information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

Consequences if No Treatment Is Administered, Not Limited to the Following:

_____ I understand that if no treatment is administered or if ongoing treatment is interrupted or discontinued, my current periodontal condition continue and likely worsen. This could lead to further inflammation and infection of gum tissues, tooth decay above and below the gumline, deterioration of bone, surrounding teeth and, eventually, loss of teeth.

Alternatives to Surgical Periodontal Treatment, Not Limited to the Following:

_____ I understand that given my condition, there may be no effective alternative treatments for my gum disease and for keeping my affected teeth.

I understand that every reasonable effort will be made to ensure that my condition is treated properly; however, (due to the complexity between patients, the infecting agents (bacteria), the immune system and finally maintenance and home care, it is not possible to guarantee perfect results or no risk of disease reoccurrence.

Check the boxes below that apply to you:

Consent

□ I have been informed, both verbally and by the information provided on this form, of theand benefits and alternatives to the proposed treatment.

□ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

□ I certify that I have read and understand the above information that the explanations referred to are understood by me, that my questions have been answered and the blanks requiring insertions or completion have been filled in. I authorize and direct Dr._____ to do whatever he/she deems necessary and advisable under the circumstances.

□ I consent to have the above mentioned treatment.

□ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

□ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with _____ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date