deborahruprecht DDS
periodontics & implant specialty

GINGIVAL GRAFTING SURGERY CONSENT FORM

PATIENT NAME: _____ DATE: _____TOOTH: _____

Upper Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Lower Left

DIAGNOSIS: After a careful oral examination and study of my dental condition, Dr. Ruprecht 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 gum line or crown with edges under the gum line, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges of crowns. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

RECOMMENDED TREATMENT: In order to treat this condition, Dr. Ruprecht, has recommended that gingival augmentation (gum grafting) procedures be preformed in areas of my mouth, which have 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 tissue from elsewhere in my mouth. The transplanted strip of gum tissue 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. A periodontal bandage or dressing may be placed.

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 gum line, to prevent root sensitivity or root decay.

PRINCIPLE RISKS AND COMPLICATIONS: I understand that a small number of 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 exposed root surface may not be completely successful. Indeed, as in some cases, it may result in more recession or with increased spacing between the teeth.

I understand that complications may result from gingival augmentation or from anesthetics. These complications include, but are not limited to: (1) post-surgical infection, (2) bleeding, swelling, and pain, (3) facial discoloration, (4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, (5) allergic reactions, and (6) accidental swallowing of foreign matter. The exact duration of any complications cannot be determined and may be irreversible. There is no method that will accurately predict of evaluate how my gum tissue and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In a addition, the success of gingival augmentation can be affected by medical

Initial here _____

32241 Crown Valley Parkway, Suite 250 •Monarch Beach, CA 92629
Telephone: (949) 248-3848 • Fax: (844)272-1012 • Email: RuprechtDDS@gmail.com
www. orangecountyperiodontist.com

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. Ruprecht any prior drug reactions, allergies, diseases, symptoms, habits or conditions that may in a way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by Dr. Ruprecht and taking all medications as prescribed is important to the success of the procedure.

ALTERNATIVES TO SUGGESTED TREATMENT: Dr. Ruprecht 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.

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 their artificial replacement 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. Ruprecht can evaluate and report on the outcome of my surgery. 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 Dr. Ruprecht and dentists for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

NO WARRANTY OR GUARANTEE: I 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 even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

PUBLICATIONS OF RECORED: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purpose. My identity will not be revealed to the general to the general public, however, without my permission.

I have been fully informed of the nature of gingival augmentation surgery, the procedure to be utilized, the risks and benefits of such surgery, the alternative treatments available, and the necessity for follow-up 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 Dr. Ruprecht. After thorough deliberation, I hereby consent to the performance of gingival augmentation surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Ruprecht.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT

Signature or Patient, Parent or Guardian	Date
Printed Name of Patient	Relationship to patient
Signature of Witness	Date

32241 Crown Valley Parkway, Suite 250 ●Monarch Beach, CA 92629
Telephone: (949) 248-3848 ● Fax: (844)272-1012 ● Email: RuprechtDDS@gmail.com
www. orangecountyperiodontist.com