PATIENT'S CONSENT FOR PERIODONTAL SURGERY

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

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of periodontal disease in my mouth and that this involves the weakening of support to my teeth by first producing a separation of the gum from the teeth (pockets). This follows for the greater accumulation of bacteria under the gum in hard to clean areas, which can result in my body's defense reactions or infections, resulting in the erosion or loss of bone supporting the roots of my teeth.

RECOMMENDED TREATMENT: In order to treat this condition, it has been recommended that my treatment include periodontal surgery. I understand that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

PURPOSE OF PERIODONTAL SURGERY: I have been informed that the purpose of this procedure is to allow access for the cleaning of the roots of teeth and the lining of the gum as well as to treat irregularities to the jaw bones surface so that when the gum is replaced about the teeth, it will allow for the reduction of pockets, infection, and inflammation. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and the ability of professionals to better clean my teeth of tarter and bacteria. The reduction of infection and inflammation should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated areas(s).

ALTERNATIVE TO THE SUGGESTED TREATMENT: These may include: (1) no treatment with the expectation of the advancement of my condition resulting in the possible premature loss of teeth: (2) extraction of teeth involved with periodontal disease: (3) attempts to further reduce bacteria and tarter under the gum line by non-surgical scraping of tooth roots and lining of the gum (root planing and curettage) with the exception that this will not fully eliminate deep bacteria and tarter, result in only partial and temporary reduction of inflammation, will not reduce gum pockets and will require more frequent professional care and may result in the worsening of my condition and the premature loss of teeth.

Initial here______________

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RISKS RELATED TO THE SUGGESTED TREATMENT: Risks related to periodontal surgery might include but are not limited to post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient or on occasion permanent numbness of the lip, tongue, teeth, chin, or gum, jaw joint injuries or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweets or acidic food. Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetic.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infections, or further bone loss or gum recession. It is anticipated (hoped) that surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth; but, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective treatment, or worsening of my present condition including the possible loss of certain teeth with the advanced involvement despite the best care.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material or the use of material to guide (enhance) tissue regeneration or termination of the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that **smoking and/or alcohol intake may effect gum healing and may adversely affect the successful outcome of my surgery**. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THERE USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for there educational use in lectures or publications provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all, procedures related to periodontal flap surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

_______________________________ _______________________

Signature or Patient, Parent or Guardian Date

_______________________________ _______________________

Printed Name of Patient Relationship to patient

_______________________________ _______________________

Signature of Witness Date

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