deborahruprecht DDS
periodontics & implant specialty

PATIENT'S CONSENT FOR GINGIVAL GRAFTING SURGERY

Name: _____ Date: _____ Tooth: _____

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

EXPLANATION OF DIAGNOSIS: After having a careful oral examination and study of my dental condition, I have been informed that I have significant gum recession and that with this condition, further recession of the gum may occur. Treatment is recommended to provide sufficient width of attached gum to withstand the irritation caused by fillings or edges of crowns and may include placing gum tissue to improve appearance and protect the roots of teeth.

RECOMMENDED TREATMENT: To relieve this condition, treatment that includes gingival grafting is recommended. I understand that sedation may be used and that a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves transplanting a thin strip of gum tissue from elsewhere in my mouth onto the base of the remaining gum in the affected area or placed to partially cover the tooth root surface exposed by recession. A periodontal bandage or dressing may be placed over the grafted site.

EXPECTED BENEFITS: The purpose of gingival grafting is to attach an adequate amount of gum tissue to reduce the likelihood of further gum recession, as well as to cover exposed root surfaces, enhance the appearance of the teeth and gum line, and prevent root sensitivity or root decay.

ALTERNATIVES TO THE SUGGESTED TREATMENT: Alternatives may include: 1) no treatment, and the expectation that my condition may advance; 2) continued monitoring for progressive recession; 3) a modified technique for brushing my teeth.

PRINCIPLE RISKS AND COMPLICATIONS: I understand that a small number of patients do not respond successfully to gingival grafting and that a tissue transplant placed over an exposed root surface may shrink back during healing. In some cases, the attempt to cover the exposed root surface may not be completely successful and may also result in more recession or increased spacing between the teeth. Additional risks relating to gingival grafting include but are not limited to: post-surgical infection, bleeding, swelling, pain, facial discoloration, transient or possibly permanent numbness of the lip, tongue, teeth, chin, or gum; jaw joint injury or associated muscle spasms, and transient or possibly permanently increased tooth looseness or tooth sensitivity to hot, cold, sweet, or acidic foods. Risks related to anesthetic may include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, soreness, or discoloration at the site of the anesthetic injection. The exact duration of any complications cannot be determined and may be irreversible.

I understand there is no method to accurately predict or evaluate how my gum tissue and bone will heal, and there may be a need for a second procedure if the initial surgery is not satisfactory. I also acknowledge the success of gingival grafting can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications I may be taking. To my knowledge, I have reported any prior drug reactions,

Initials: _____

allergies, diseases, symptoms, habits or conditions to the doctor that may relate to this surgical procedure.

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. It is anticipated that surgery will provide benefit in reducing the cause of my condition and produce healing that will enhance the possibility that I may retain my teeth longer. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, even with the best of care, there exists the risk of failure, relapse, need for selective re-treatment, or worsening of my present condition, including the possible loss of certain teeth due to advanced involvement.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that **smoking and/or alcohol intake may affect 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 and the use of prescribed medications. I agree to report for appointments following my surgery so the doctor may monitor my healing, evaluate and report the outcome of surgery, and if necessary, adjust prosthetic appliances. I also understand that since existing restorative dentistry is an important factor in the success or failure of gingival grafting, it is important for me to see my regular dentist as recommended.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed without my permission.

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

_____	_____
Signature of Patient or Parent/Guardian	Date
_____	_____
Printed Name of Patient	Relationship to Patient
_____	_____
Signature of Witness	Date