deborahruprecht DDS
periodontics & implant specialty

PATIENT'S CONSENT FOR PERIODONTAL 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: I have been informed of the presence of periodontal disease in my mouth and I understand this involves the weakening of support to my teeth by first producing a separation of the gum from the teeth (pockets). This allows 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's bone 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 tartar 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 area(s).

ALTERNATIVE TO THE SUGGESTED TREATMENT: The alternative may include: (1) no treatment, and the expectation that my condition will advance and result in the possible premature loss of teeth; (2) extraction of teeth involved with periodontal disease; (3) attempts to further reduce bacteria and tartar 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 tartar, 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.

PRINCIPLE RISKS AND COMPLICATIONS: Risks related to periodontal surgery may include but are not limited to: post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient or possibly permanent numbness of the lip, tongue, teeth, chin, or gum; jaw joint injury or associated muscle spasms, transient or possibly permanently increased tooth looseness, or tooth sensitivity to hot, cold, sweet, or acidic foods. Risks related to anesthetic might 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.

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 that surgery will provide benefit in

Initials: _____

reducing the cause of this condition and produce healing that will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective re-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: Unforeseen conditions may be discovered during surgery that may 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 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 to the use of prescribed medications. I agree to report for appointments following my surgery as suggested so my healing may be monitored, and the doctor can evaluate and report the outcome of surgery upon completion of healing.

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.

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