Periodontal & Implant EXCELLENCE

PRACTICE LIMITED TO PERIODONTICS, IMPLANTS & COSMETIC PERIODONTICS

INFORMED CONSENT FOR PERIODONTAL SURGERY

DIAGNOSIS

After a careful oral examination, review of my x-rays films, and study of my dental condition my periodontists has advised me that I have periodontal disease and/or conditions in my gums that are unfavorable for the health of my teeth. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth and possibly destroying some of the bone that supports the tooth roots.

RECOMMENDED TREATMENT

In order to treat this condition, my periodontist has recommended that my treatment include periodontal surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment.
I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These include, but are not limited to (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

EXPECTED BENEFITS

The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the fullest extent possible. The surgery is intended to help keep my teeth in my operated areas and to make oral hygiene more effective. It should also enable professionals to better clean my teeth.

PRINCIPAL RISKS AND COMPLICATIONS

I understand that a small number of patients do not respond successfully to periodontal surgery, and in such cases, the involved teeth may eventually be lost. Periodontal surgery may not be successful in preserving function or appearance because each patient's condition is unique and long-term success may not occur.

I understand the complications may result from periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to, post-surgical infection, bleeding, swelling and pain, tooth sensitivity to hot, cold, sweet or acid foods, and shrinkage of the gum upon healing. I understand that there may be a need for a second procedure if the initial results are not satisfactory.

ALTERNATIVES TO SUGGESTED TREATMENT

I understand that alternatives to periodontal surgery include: no treatment (with the expectation of possible advancement of my condition which may result in premature loss of teeth); extraction of the teeth involved with periodontal disease, and non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medication, in an attempt further to reduce bacteria and tartar under the gum line. The expectation is known that this may not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care, and may not address the worsening of my condition and the premature loss of teeth.

NO WARRANTY OR GUARANTEES

I hereby acknowledge there is no guarantee. There is no absolute cure to periodontal disease, but there are in fact very effective treatments that allow patients to keep their teeth in a healthy state for a lifetime. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There exists a risk of failure, relapse, the need for additional treatment, or even worsening of my present condition, including the possible loss of teeth, despite the best of care.

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of the procedure, and the necessity for follow up and self care. I have had the opportunity to ask any questions that I may have in connection with the treatment and to discuss my concerns with the periodontist. After thorough deliberation I hereby consent to the performance of periodontal surgery as presented to me during consultation and 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 my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

Patient Name-Parent Guardian Date

_____ _____

Witness Date

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