INFORMED CONSENT DISCUSSION FOR SURGICAL PERIODONTAL TREATMENT

Patient name: _____ **Date of Birth:** _____

DIAGNOSIS: _____

Facts for Consideration

Patient's initials required

_____ Dental x-rays will be taken to check the condition of the bone that supports your teeth. A thorough examination of your oral cavity will be done measuring the pockets under the gums surrounding your teeth to determine which periodontal treatment(s) your gum condition requires.

_____ One type of surgical treatment, called a ***gingivectomy***, is the surgical removal of diseased gingiva (gum tissue) to reduce or eliminate periodontal pockets that have failed to respond to more conservative treatment such as scaling and curettage. It includes deep scaling and planing of the root surfaces exposed during the surgery. Sedation or premedication may be prescribed for you prior to the surgery.
Approximate Cost: _____.

_____ Treatment may also include ***flap surgery*** which involves cutting and lifting up a small area of the gums to expose the boney defect around the tooth. The affected tissue may be cleaned out, the bone recontoured, or real or synthetic bone material may be grafted into the site. A barrier membrane may also be inserted and sutured into place, and a periodontal dressing may be placed over the area of surgery.
Approximate Cost: _____.

_____ A ***gingival graft*** involves moving gum tissue from one site to another. Often this is done to cover an exposed root, or to provide a zone of attached gingiva around a tooth where the normal tissue has receded.
Approximate Cost: _____.

_____ The success of the treatment depends in part on your efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow proper home care taught to you by this office.

_____ A topical or local anesthetic is administered depending on the location and depth of the area to be treated.

Benefits of Surgical Periodontal Treatment, Not Limited to the Following:

_____ Surgical periodontal treatment can: help to create a clean environment in which your gums can heal; help to reduce the chances of further gum irritation or infection; make it easier for you to keep your teeth clean; improve your chance to retain teeth and their function; and decrease the cost of replacing teeth lost due to gum disease. This course of treatment will help to improve your condition and prevent this disease from spreading.

Risks of Surgical Periodontal Treatment, Not Limited to the Following:

_____ **I understand** that my gums may bleed or swell and I may experience **moderate discomfort** for several hours after the anesthesia wears off and there may be slight **soreness** for a few days which may be treated with pain medication. I will notify the office if conditions persist beyond a few days.

_____ **I understand** that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an **infection,** which would be treated with antibiotics. I will immediately contact the office if I experience fever, chills, sweats or numbness.

_____ **I understand** that holding my mouth open during treatment may temporarily leave my **jaw feeling stiff and sore** and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. **I must notify your office** if this or other concerns arise.

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_____ **I understand** that as my gum tissue heals, it may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to **hot or cold**. I also understand that following treatment, I may have **spaces between my teeth** at the gumline, which could trap food particles and require special maintenance. **I understand** additional surgical procedures are available to protect the sensitive areas.

_____ **I understand** that depending on my current dental condition, existing medical problems, or medications I may be taking, these methods alone **may not completely reverse** the effects of gum disease or prevent further problems. Teeth that become loose as a result of periodontal disease may be extracted, which may require replacing the teeth with a fixed or removable bridge, denture, or artificial teeth called *implants.*

_____ **I understand** that I may receive a **topical or local anesthetic and/or other medication**. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention. Depending on the anesthesia and medications administered, I may need a **designated driver to take me hom**e. Rarely, temporary or permanent nerve injury can result from an injection.

_____ **I understand** that all **medications** have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking, which are: _____

_____

_____ **I understand** that every reasonable effort will be made to ensure that my condition is treated properly, although it is not possible to guarantee perfect results. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

Consequences If No Treatment Is Administered, Not Limited to the Following:

_____ **I understand** that if **no treatment** were administered or ongoing treatment was interrupted or discontinued, my periodontal condition would continue and probably worsen. This could lead to further inflammation and infection of gum tissues, tooth decay above and below the gumline, deterioration of bone surrounding the tooth and eventually, the loss of teeth.

Alternatives to Surgical Periodontal Treatment, Not Limited to the Following:

_____ **I understand** that given my condition, there are **no effective alternative treatments** for my severe gum disease and keeping my affected teeth.

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

☐ **I consent to the circled surgical periodontal treatment(s) described above by Dr. _____.**

☐ **I refuse to give my consent for the proposed treatment(s) as described above.**

☐ **I have been informed of and accept the consequences if no treatment is administered.**

_____ _____

Patient's Signature Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to the circled surgical periodontal treatment with _____ (patient's name), who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____ _____

Dentist's Signature Date

_____ _____

Witness' Signature Date