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INFORMED CONSENT FOR PERIODONTAL OSSEOUS SURGERY

After a careful oral examination, radiographic evaluation and study of my dental condition, my periodontist has advised me that I have bone loss and/or gum pockets around my teeth from periodontal disease. 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. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard-to-clean areas and can result in further loss or erosion of bone and gum tissue supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health. Various forms of periodontal diseases are fairly common and advanced periodontal disease is the primary reason adults lose teeth.

Recommended Treatment: My periodontist has recommended periodontal osseous surgery. I understand that a local anesthetic will be administered as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth. During the surgery, my gum will be trimmed and pulled away from the teeth to permit better access to the roots and to the eroded bone. The following treatment and/or therapy may be performed:

- Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned.
- Bone irregularities may be reshaped.
- Bone regenerative material (grafting) may be placed around my teeth.

I understand various types of graft materials may be used. These materials may include my own bone or gum, synthetic bone substitutes, or bone obtained from certified tissue banks. Membranes may be used with or without graft material depending on the type of bone defect present.

My gum will then be sutured back in place closer to the new bone level and a periodontal bandage or dressing may be placed. The surgery will make it look like the gum has receded, making the teeth look longer and resulting in spaces between them as the gum papilla (the pointy part of the gum between the teeth) is lower.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to the following: **(1)** extraction of hopeless teeth to enhance healing of adjacent teeth, **(2)** the removal of a hopeless root of a multi-rooted tooth so 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 osseous surgery is to reduce infection, inflammation and to reshape bone deformities created by periodontal disease to reduce the gum pockets. The surgery is intended to help me significantly improve the chances of keeping my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth. The use of my own bone, gum grafts, bone graft material, or the placement of a protective membrane is intended to enhance bone and gum healing.

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 my eventually be lost. Periodontal surgery may not be successful in preserving the function or appearance. Since each patient's condition is unique, long-term success may not occur. Complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to the following: post-surgical infection, bleeding, swelling and pain; facial discoloration; muscle spasm; permanent increased tooth looseness; tooth sensitivity to hot, cold, sweet or acidic foods; shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth; cracking or bruising of the corners of the mouth; restricted ability to open the mouth for several days or weeks; impact on speech; allergic reactions; and accidental swallowing of foreign matter. In the event that donated tissue is used for the graft, the tissue should have been tested for hepatitis, HIV, and other transmittable infectious diseases. Nevertheless, there is a remote possibility that tests will not determine the presence of diseases in a particular donor tissue. The exact duration of any complications cannot be determined, and they may be irreversible.

I understand that there is no method that will accurately predict or evaluate how my gum and bone will heal. I understand there may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed is important to the ultimate success of the procedure.

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Alternatives to Suggested Treatment: I understand that alternatives to periodontal surgery include no treatment. By electing no treatment I can expect possible advancement of my condition which may ultimately result in the following: **(1)** premature loss of teeth; **(2)** extraction of teeth; and **(3)** non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medication, in an attempt to further reduce bacteria and calculus under the gumline—with the expectation that this may not fully eliminate deep bacteria and calculus, may not reduce gum pockets, will require more frequent professional care, time and commitment, and may not arrest the worsening of my condition.

Necessary Follow-Up and Self-Care: I understand that it is important for me to continue to see my general dentist and the periodontist for regularly scheduled hygiene maintenance visits. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my periodontist may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more teeth, the extraction of one or more teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I know that it is important to: **(1)** abide by the specific prescriptions and instructions given; **(2)** see my periodontist for post-operative check-ups as needed; **(3)** not smoke or use smokeless tobacco; **(4)** perform excellent oral hygiene as instructed; and **(5)** stay on a regular hygiene maintenance schedule.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use an additional form of birth control along with my birth control pills for one complete cycle after a course of antibiotics is completed.

Administration of Local Anesthetic: Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs until fully recovered from their effects.

No Warranty or Guarantee: There is no method that will accurately predict or evaluate how my gum and bone will heal. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases it should be, however, due to individual patient differences there can never be a certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including possible loss of teeth despite the best of care.

Communication with Insurance Companies and Dental/Medical Providers: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carrier(s), the doctors' billing agency, my general dentist, and any other health care provider involved with my case who may have a need to know about my dental treatment.

PATIENT CONSENT

I certify that I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of such surgery, the alternative treatments available, the necessity for follow-up and self-care, and that there are no guarantees. I have had the opportunity to ask questions in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described 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 AND CONSENT TO PERIODONTAL OSSEOUS SURGERY.

_____ _____
Signature of Patient (Parent/Guardian) Date

_____
Printed Name of Patient (Parent/Guardian)

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

Initial and Date If Applicable:

Patient: _____; _____; _____
2nd Surgery 3rd Surgery 4th Surgery

Witness: _____; _____; _____
2nd Surgery 3rd Surgery 4th Surgery