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Consent for Use of GINGIVAL GRAFT SURGERY

An explanation of your need for gingival grafting its purpose and benefits, the surgical procedure for gingival grafting, its possible complications as well as alternatives to gingival grafting were discussed with you at your consultation and we obtained your verbal consent to undergo the treatment planned for you. Please read this document which repeats issues we discussed in its entirety and provide the appropriate signatures on the last page. Please excuse us for this inconvenience and do ask us to clarify anything that you do not understand.

EXPLANTIONS OF DIAGNOSIS: I have been informed of the presence of significant gum recession in my mouth. I understand that it is important to have a sufficient width of (attached gingiva) around the base of the teeth (at the gum line) such that it minimizes the probability of food particles and bacteria lodging between the gum and teeth. I understand that where there is insufficient attached gingiva (gum) and food or bacteria become lodged under the gum line, this ma result in further recession of the gum or in a localized infection (gum abscess). I also understand that where there are fillings at the gum line or crowns (caps) with edges under the gum line, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or caps or the material from which they are made do not cause significant irritation to the gum.

PURPOSE OF GINGIVAL GRAFTING: I have been informed that the purpose of gingival (gum) grafting is to create an adequate band (width) of attached gum tissue so as to prevent the likelihood of further gum recession. .

SUGGESTED TREATMENT: It has been suggested that gingival grafting be performed in areas of my mouth where I have significant gum recession. It has been explained that this is surgical procedure involving the removal of a thin strip of gum from the roof of my mouth alongside the upper teeth and transplanting it to the area of significant gum recession. There, it can be placed at the base of the remaining gum or it can be placed so as to partially cover the tooth root surface exposed by the recession. If the latter is attempted, I understand that the gum placed over the root may shrink back during healing and that the attempt to cover the exposed root surface may not be completely successful.

RISK RELATED TO THE SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to gingival grafting might include postoperative bleeding, swelling, pain, infection, facial discoloration, transient or on occasion permanent tooth sensitivity to hot or cold or sweats or acidic foods. Risks related to the local anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain soreness or discoloration at the site of injection of the anesthetics.

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, infection or further bone loss or recession. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth by reducing the likelihood of further gum recession in the treated area(s)t but due to individual patient differences one cannot predict the absolute certainty of success. Therefore there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition.

COMPLIANCE WITH SELF-CARE INSTRUCTONS: I understand that excessive smoking and/or alcohol intake may effect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

SUPPLIMENT AL 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.

PATIENTS ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to gingival graft surgery as presented to me during consultation and treatment plan presentations by the doctor or/as described in this document.

______________________________ __________ ______________________________

Patient's Signature (Signature of Patient or Legal Guardian if the patient is a minor) Date Relationship to Patient

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Patient's Name

______________________________ ______________

Signature of Witness Date

As part of this consent agreement, I give my personal pledge, as a health care professional dedicated to the well being of my patients, to make every reasonable effort to assure that this patient receives the best care possible with the least possible risk.

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Signature of Doctor Date