**Type of Surgical Treatment to be Completed**

\_\_\_\_\_ Periodontal Surgery \_\_\_\_\_ Implant Placement

\_\_\_\_\_ Bone Grafting for Tooth Preservation \_\_\_\_\_ Sinus Bone Grafting (Augmentation)

­\_\_\_\_\_\_Crown Lengthening / Gingivectomy \_\_\_\_\_ Removals/Extractions

\_\_\_\_\_ Gingival Augmentation / Gum Grafting \_\_\_\_\_ Bone Preservation Grafting/Ridge Augmentation

**\_\_\_\_\_** Frenulectomy **\_\_\_\_\_** Surgical Exposure

**\_\_\_\_\_** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to treat my current periodontal condition, my periodontist has recommended that my treatment may include any of the surgical procedures as noted above. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of my treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth. During this procedure my gum will be opened to permit better access and will then be sutured back into position. I consent to the use of grafting materials that are tested and safe. This may include materials from bovine, porcine and human (allograft) origins.

**Expected Benefits:**

\_\_\_\_\_ **Periodontal Surgery and Bone Grafting:** The purpose periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the greatest extent possible. The surgery is intended to help me keep my teeth longer in the treated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

\_\_\_ \_\_ **Crown Lengthening:** I understand that crown lengthening may be done for my dentist to better restore my tooth or teeth. It may also be done for cosmetic reasons in some cases.

\_\_\_\_\_ **Gingival Augmentation:** The reason for gingival grafting is to increase the thickness and strength of gum tissue and to reduce the likelihood of further recession. In some cases, root coverage may decrease the risk of inflammation, root decay, and sensitivity.

\_\_\_\_\_ **Removals:** I understand the reason for the removal of my tooth or teeth. I have agreed to the benefit of removing my tooth or teeth. The removal of a tooth may be necessary for the following reasons: poor or non-restorable prognosis, root fracture, significant periodontal disease, or inability to be used in restoring my mouth with functioning teeth.

\_\_\_\_\_ **Implant Related Procedures:** The purpose of gingival augmentation, bone grafting, sinus augmentation and implant procedures are to be able to replace some teeth with implant supported crowns, bridges or dentures. This process can take significant time for healing and often requires multiple steps and surgeries.

**Principle Risks and Complications:** I understand that a small number of patients do not respond successfully to periodontal or implant surgery. In such cases, the involved teeth or implants may be lost. The procedure may not be successful in preserving and/or achieving function or appearance. Each patient’s condition is unique and long-term success may not occur. I understand that complications may result from the surgery, drug or anesthetics. These complications include but are not limited to post surgical infection, bleeding, swelling, pain, facial discoloration (bruising), transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increases in tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods, shrinkage of gum upon healing resulting in elongation of some of the teeth (negative cosmetic changes),open gum spaces between teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact of speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible. Setter Periodontics will make every effort to avoid and prevent complications as well as provide post-operative care to manage any unforeseen complications.

I understand that there may be a need for other procedures if the 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 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, which might in any way relate to the surgical procedure. I understand that my diligence in following post-operative instructions, taking all prescribed medication, and providing the personal daily and recall care recommended by my periodontist are important to the ultimate success of the treatment.

**Alternatives to Suggested Treatment:** I understand the alternatives to treating periodontal disease and gum recession include “no treatment” – with the expectation of possible advancement of my condition which may result in premature loss of teeth.

Alternatives to implant-related procedures such as partial dentures and fixed bridges have been discussed, and I understand the reasons that I have chosen this treatment. I understand the crowns on the implants are completed by my restorative dentist and his or her fees are separate.

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

I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to commit to appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for examination and preventative treatment. Maintenance may also include the adjustment of prosthetic appliances.

**No Warranty or Guarantee:** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefits in reducing the cause of my condition and should produce healing which will help me keep my teeth or replace teeth with dental implants. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

**Publication of Records:** I authorize photos, slides, radiographs or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes without compensation to me. My identity will not be revealed to the general public without my permission.

**Patient’s Statement of Consent:**

I have been fully informed of the nature of the proposed surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatment available, and the necessity for follow-up self care. I have had an opportunity to ask any questions I may have 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 have read and understand all of the above and have had my questions answered.**

Patient’s Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_