

## Periodontal Treatment Consent Forms

Patient Name: \_\_\_\_\_ Treatment Being Rendered: \_\_\_\_\_

**Diagnosis:** After a careful oral examination and study of my dental condition, my periodontist has advised me that I have gingival disease, occlusal trauma, periodontal disease, mucogingival deformities, partial or complete edentulism. I understand that periodontal disease weakens the 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 erosion or loss of bone and gum 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.

**Recommended Treatment:** In order to treat this condition, my periodontist has recommended that my treatment includes non-periodontal surgery or periodontal surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. Some non-surgical treatments include oral hygiene and disease prevention, microbial cultures, pocket irrigation antibiotic therapy (systemic or local), polishing and scaling and root planning, occlusal adjustment, occlusal guards, tooth splinting or tooth straightening procedures. Surgical procedures include but not limited to gingivoplasty, gingivectomy, flap surgery with or without osseous recontouring, osseous/alloplastic grafts, guided tissue generation, guided bone regeneration, soft tissue grafts, biopsy, frenectomy, crown lengthening, implants, sinus elevations and preprosthetic surgery. During the procedure, my gums will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed and root surfaces will be thoroughly cleaned. I further understand that antibiotics and other substances may be applied to the roots of my teeth. Bone irregularities may be reshaped and/or bone regenerative material may be placed around my teeth. If implants are anticipated, bone augmentation may need to be done prior to implant placement. If implants are placed at the time of surgery, bone may need to be placed simultaneously. Furthermore, pending upon the stability of the implant, either one two stage approach will be performed. If two stage procedure is needed, additional treatment may need to be done such as a soft tissue graft at the time of stage II. If maxillary sinus needs to be elevated, the surgeon will make the decision as to whether the implants will be placed simultaneously. My gums will then be sutured back into position. I further understand that unforeseen conditions may call for modification or change from the anticipated surgical plan. These may include but not limited to extractions of teeth, removal of hopeless roots or termination of the procedure prior to completion of all the surgery originally outlined.

**Expected Benefits:** The purpose of periodontal surgery is to reduce the infection and inflammation in order to restore my gums and bone to a healthy condition. The surgery is intended to help keep my teeth in the operated areas and to make my oral hygiene more effective. Preprosthetic surgery will allow the restorative dentist to provide a functional prosthesis. It should enable professionals to better clean my teeth.

**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, long term success may not occur. I understand that complications may result from the periodontal surgery, drugs and anesthetics. These complications include but are not limited to **post-surgical**

infection, bleeding, swelling, pain, possible implant failure, sinus communication/ involvement, vertigo, facial discoloration, transient but on occasion permanent numbness or the jaw, lip, tongue, chin or gums; jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic food, shrinkage of the gums upon healing resulting in elongation of some teeth, exposure of crown margins and greater spaces and food impaction between some teeth, possible tooth caries, cracking or bruising of the corners of the mouth, restricted opening of the mouth for several days or weeks, impact on speech, allergic reactions and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined and they may be irreversible. There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that 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, disease, symptoms, habits or conditions which might in any way relate to this surgical procedures.

**Necessary Follow Up Care and Self Care:** I understand that it is important for me to **continue to see my regular dentist especially for cleaning and caries detection.** 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, replacement or medications of existing restorations, joining together of two or more teeth, extraction of teeth and root canal therapy. 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 their artificial replacements should be maintained daily in a clean hygienic manner.** I will need to come for 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. **Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery.** I know that it is important to abide by specific prescriptions and instructions given by the periodontist and to see my periodontist and dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

**No Warrantee or Guarantee:** I hereby acknowledge that no guarantee, warrantee or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keeping my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a 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.

I, in sound mind, certify that I have read all the information and have had all my questions answered so that I understand the above consent to treatment, the explanation therein referred to or made, and that all blanks or statements requiring insertion or completion were filled in an inapplicable sections, if any, were stricken before I signed.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_