



107 Frazier Court, Suite 1D
Georgetown, KY 40324
Phone: (502) 570-5700

Consent to Surgery

Our practice is committed to providing our patients with the finest care possible. We want the very best results but healing can be different from person to person. We must inform you of the positive and negative possibilities of treatment as well as alternatives. Please do not be offended by having to sign this form. We are guided by our obligation to you and the ethical standards of our profession.

Type of Surgical Treatment to Be Completed

☐ Periodontal Surgery ☐ Crown Lengthening Surgery
☐ Bone grafting for teeth ☐ Gingival Augmentation Surgery (Gum Grafting)
☐ Implant Placement ☐ Extraction Consent-Tooth (Teeth) # _____
☐ Sinus Lift-Augmentation ☐ Sedation ☐ IV ☐ Oral ☐ N2O ☐ General Anesthesia
☐ Biopsy

In order to treat my current periodontal condition, my periodontist has recommended that my treatment may include the surgical procedures as noted above. I understand that sedation may be utilized and that a local anesthetic will be administered to me as a part of the treatment. In the event of sedation, I understand that wrist restraints and/or stabilization boards may be utilized if necessary and will function as a safety precaution and stabilization method. 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 (allografts) origins. I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan or termination of the procedure prior to the completion of all the surgery originally outlined.

Expected Benefits

☐ **Extraction:** I understand the reason for the extraction of my tooth or teeth. I have agreed to the benefit of extracting my tooth or teeth. The reason for extraction can include being non-restorable, having a root fracture, significant periodontal disease or its inability to be used in restoring my mouth with functioning teeth replacements.

☐ **Periodontal Surgery and Bone Grafting:** The purpose of 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 operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

☐ **Gingival Augmentation:** The reason for gum grafting is to create the amount of gum adequate to reduce the likelihood of further recession. In some cases root coverage may decrease the risk of root decay and sensitivity.

☐ **Implant Related Procedures:** The purpose of Gum grafting, Bone Grafting, Sinus Lifts and Implant procedures are to be able to replace some teeth with implant supported crowns. This can take significant time required for healing.

☐ **Biopsy:** The purpose of a biopsy is to remove tissue to send an oral pathologist to determine a diagnosis for a disease or lesion occurring in the oral cavity.

Principle Risks and Complications: I understand that a small number of patients do not respond successfully to periodontal surgery or implant surgery. In such cases, the involved teeth or implants may be lost. The surgery may not be successful in preserving and/or achieving function or appearance. Each patient's condition is unique, long-term success may not occur. I understand that complications may result from the surgery, drugs 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 increased tooth looseness, tooth sensitivity to hot, cold, sweet or acid foods, shrinkage of the gum upon healing resulting in elongation of some teeth(negative cosmetic changes), open gum spaces between teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth, 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. I understand the 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 providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to the 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 done with 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 of 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 appliances 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 upon completion of healing. Smoking or alcohol intake may adversely affect gum 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 periodic examination and preventative treatment. Maintenance also may include 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 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.

Patients 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 available and the necessity for follow-up and 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 judgement of my periodontist.

Consent for Sedation: I understand that sedation may impair my judgement, coordination, and ability to operate machinery or drive a motor vehicle safely. I have been clearly informed that I must not drive, operate heavy machinery, or make important decisions for at least 24 hours after receiving sedation. I have also arranged for a responsible adult to accompany me and drive me home after the procedure.

I have read and understand all of the above.

Patients Name (Please Print) _____

Patients Signature: _____ **Date** ____/____/____

Witness Signature: _____ **Date** ____/____/____