Informed Consent for Periodontal (Gum) Surgery

I hereby authorize my doctor to perform periodontal surgery upon:

_____
(Tooth Numbers)

I have been informed that the purpose of the operation is to surgically treat and possibly correct my periodontally diseased gum tissues, teeth and supporting jawbones.

I have been advised that sedative drugs will be administered during surgery. I therefore agree that I will not drive myself home after surgery, but will arrange to be driven and accompanied home.

In the event that extraction of any teeth is deemed advisable by my doctor due to conditions visualized and determined at the time of surgery, I hereby consent to all such extractions.

If any unforeseen conditions should arise in the course of the operation, calling for my doctor's judgment or for procedures in addition to or different from those now contemplated, I further request and authorize my doctor to do whatever may deem advisable.

Further, I have been informed of other possible alternatives and/or supplemental methods of treatment.

Post-operative risks of the proposed surgery include, but are not limited to: swelling; infection; pain; restricted mouth opening for several days, weeks or longer; paresthesia (numbness) of the jaw or gum nerves which may persist for several weeks, months or in remote instances, permanently; gum recession (shrinkage); temporary or, in rare instances, permanent interference with phonetics (speech sounds); clicking or pain of the temporomandibular joints (jaw joints); tooth sensitivity to hot or cold for days, weeks or on occasion, several months; transient or in some instances permanent, tooth mobility (looseness) in selected areas; food lodging between the teeth after meals, requiring cleaning devices such as floss for removal; and unesthetic exposure of crown (cap) margins.

I further understand that if no treatment is rendered, my present periodontal condition will probably worsen in time, which may result in premature tooth loss.

No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, secretive re-treatment or worsening of my present condition despite the best care. However, it is my doctor's opinion that therapy will be helpful and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment.

I understand that long-term success requires my long-term continued performance of mechanical plaque removal (daily home care as recommended) and my availability for periodic periodontal maintenance visits (recall professional care) as advised.
I consent to photographs of my oral and facial structures and their publication for educational and scientific purposes.
I understand that any questions I may have will be answered prior to surgery.
I understand that I will have the opportunity to obtain a second opinion if I should so desire, prior to surgery.

I CERTIFY THAT I HAVE READ FULLY AND UNDERSTAND THE ABOVE CONSENT TO THE OPERATION, THE EXPLANAITON THEREIN REFERRED TO OR MADE AND THAT ALL INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I UNDERSTAND THAT I MAY WITHDRAW MY CONSENT AT ANYTIME PRIOR TO THIS SURGERY.

_____	_____
Signature of Patient or Guardian	**Date**
_____	_____
Signature of Witness	**Date**
_____	_____
Signature of Doctor	**Date**