INFORMED CONSENT FOR GINGIVAL GRAFTING

An explanation of your need for gingival grafting surgery, the procedure and post-operative, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo this procedure. Please read this document which repeats issues we discussed and provide the appropriate signature. Please ask us to clarify anything that you do not understand.

Explanation of Diagnosis: I have been informed of the presence of significant gum recession in my mouth. I understand that it is important to have sufficient width of gum (attached gingiva) around the base of my teeth (at the gumline) such that it minimizes the probability of food particles and bacteria lodging between the gum and the teeth. Where there is insufficient attached gingiva (gum), food or bacteria may become lodged under the gumline which may result in further recession of the gum or in a localized infection (gum abscess). I also understand that where there are fillings at the gumline or crowns with edges under the gumline, it is important to have sufficient width of attached gingiva so that the edges of the fillings, crowns or materials 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 grafting is to create an adequate band 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 the area of my mouth where I have significant gum recession. It has been explained that this is a surgical procedure involving the removal of a thin strip of keratinized tissue 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 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.

Risks Related to the Procedure: Risks related to gingival grafting might include, but are not limited to post-operative bleeding, swelling, pain, infection, facial discoloration, transient or permanent numbness (if working in the lower area), and transient or on occasion permanent tooth sensitivity to hot or cold, sweet or acidic foods. Risks related to the 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 of 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, infections, or further bone loss or recession. It is anticipated 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), but due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective treatment or worsening of my present condition.

Initial_____

Compliance with self-care instructions: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of mouth. I agree to report for my 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.

Supplemental record and their use: I consent to photography, filming, and x-rays of my oral structure as related to these procedures and for their educational use in lectures or publications, provided my identity if not revealed.

Patient Signature: My 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 performance of any and all procedures related to gingival grafting surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

Signature:_____ Date:_____

Witness: _____