

INFORMED CONSENT FOR PERIODONTAL FLAP SURGERY

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

PURPOSE OF PERIODONTAL FLAP SURGERY: I have been informed that the purpose of this procedure is to allow access for the cleaning of the roots or teeth and the lining of the gums, as well as to treat irregularities to the jaw bone surface, so that when the gum is replaced around the teeth, it will allow for the reduction of pockets, infections and inflammation. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and of the ability of professionals to better clean my teeth of tarter and bacteria. The reduction of infection and inflammation should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated areas providing I stay on a strict maintenance schedule recommended by my dentist and follow through with my proper oral homecare.

ALTERNATIVES TO THE SUGGESTED TREATMENT: These may include: 1) no treatment with the expectation of the advancement of my condition resulting in the possible premature loss of teeth. 2) extraction of teeth involved with the periodontal disease. 3) attempts to further reduce bacteria and tarter under the gumline by non-surgical scraping of tooth roots and lining of the gums with the expectation that this will not fully eliminate deep bacteria and tarter, resulting in only partial and temporary reduction of inflammation and infection, will not reduce gum pockets and will require more professional care and may result in the worsening of my condition and the premature loss of teeth.

RISKS RELATED TO THE PROCEDURE: Risks which may be related to periodontal flap surgery might include, but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration (bruising), transient but on occasion permanent numbness of the lip, tongue, chin or gum, jaw joint injuries or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweets, acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Risks related to the anesthetics might include, but are not limited to bruising, pain, soreness or discoloration at the site of anesthetic injections.

NO WARRANTY OR 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, infection, further bone loss or gum 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, but due to individual patient difference, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective re-treatment or worsening of my present condition including the possible loss of certain teeth with advance in involvement despite the best of care.

Initial _____

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material to guide (enhance) bone regeneration prior to completion of the surgery originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgement of Dr. Avason/Dr. Manning.

COMPLIANCE OF SELF CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of the surgery. I agree to follow instructions related to my own daily care of my 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 upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structure as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

PATIENT'S 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 the performance of any and all procedures related to periodontal flap surgery as presented to me by Dr. Avason/Dr. Manning or described in this document.

Signature (or Guardian) _____ Date: _____