Donna L. Massoth, DDS, MSD, PhD, PLLC
Periodontics & Implant Dentistry

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. After a careful oral examination and study of my dental conditions, my Periodontist has advised me that in order to treat my current periodontal condition, treatment may include the surgical procedures noted below.

Types of Surgical Treatments Recommended

☐ Periodontal Flap Surgery: _____ ☐ Crown Lengthening Surgery: _____
☐ Bone Grafting for teeth: _____ ☐ Gingival Augmentation Surgery: _____
☐ Extraction- teeth#:_____ ☐ Implant Placement: _____
☐ Sinus Lift-Augmentation: _____ ☐ Bone Graft for Implant: _____
☐ Other: _____

I understand that oral sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth. During the procedure, my gum will be opened to permit better access to the roots and jaw bone, and then will be sutured back into position. I also consent to the use of grafting materials that are tested and safe. This may include materials transplanted from one part of my mouth to another, as well as, from bovine, porcine, and/or human (allograft) 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:** The reason for the extraction of my tooth or teeth can include being non-restorable, having a root fracture, infection in the root or in the gum tissue, or significant periodontal disease. I have agreed to the benefit of extracting my tooth or teeth.

_____ **Periodontal Flap Surgery/ With Bone Graft:** The purpose of periodontal surgery is to reduce infection and inflammation, gain access for cleaning the roots of the teeth beneath the gum, and to restore my gum and bone to the 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 dental professionals to better clean my teeth.

_____ **Crown Lengthening:** I understand that crown lengthening may be done for my dentist to better restore my tooth or teeth. It may also be done for cosmetic reasons in some cases.

_____ **Gingival Augmentation:** The reason for "Gum Grafting" is to create the amount of gum tissue adequate to reduce the likelihood of further gum recession. An additional benefit of this procedure may include the covering of exposed root surfaces with new tissue resulting in improved appearance of the teeth and gum line, and decreased root sensitivity and decay.

_____ **Implant Related Procedures:** The purpose of Dental Implants and related procedures such as gum grafting, bone grafting, and sinus lifts is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth. This can take significant time for healing.

Principle Risks and Complications:

I understand that a small number of people do not respond successfully to periodontal surgery or implant surgery. In such cases, the involved teeth or implants may be lost. Each patient's condition is unique, the surgery may not be successful in preserving and/or achieving function or appearance, and 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 (1) post-surgical infection (2) bleeding, swelling, pain (3) facial bruising (4) transient but on occasion permanent numbness to the lip, tongue, teeth, chin, or gum (5) jaw joint injury or muscle spasm (6) transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweets, or acidic foods (7) shrinkage of the gum upon healing resulting in elongation of some teeth, and open spaces between the teeth (8) cracking or bruising of the corners of the mouth (9) restricted ability to open the mouth for several days or weeks, (10) impact on speech, (11) allergic reactions, (12) and accidental swallowing of foreign matter. ***The exact duration of any complication cannot be determined and they may be irreversible.***

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I understand that there may be a need for additional 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 my 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 following the personal daily care techniques recommended by my Periodontist and in taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to 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 completed by my restorative dentist and his or her fees are separate.

Necessary Follow-Up Care and Self-Care:

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for several post-surgical appointments, so that my healing may be monitored, and so that my Periodontist can evaluate and report on the surgical outcome upon completion of healing. Smoking and 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 specific prescriptions and instructions given by my Periodontist and (2) to see my Periodontist and regular dentist for periodic examinations and preventative treatment including existing restorative dentistry, maintenance, and 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 causes 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 risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best care.

Publication of Records

I authorize photos, slides, x-rays, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without permission.

Patient's 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 treatment available, and the necessity for follow-up care 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 herby 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 judgment of my Periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Patient's Name (please print) _____

Patient's Signature: _____Date: _____

Witness Signature: _____Date:_____