

MILLENNIUM PERIODONTICS – INFORMED CONSENT FOR PERIODONTAL TREATMENT AND SURGERY

PATIENT _____ **DATE OF SURGERY** _____ **Vitals: BP:** _____ **; Pulse** _____

Diagnosis. After a careful oral examination and study of my dental condition, my Periodontist, Dr. Christine Gadia or Dr. Robert Busan, has advised me that I have-in all likelihood-periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from, the teeth and possibly destroying some of the bone that supports the tooth roots. The pockets cause by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further loss of bone and gum supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health.

Recommended Treatment. In order to treat this condition, I hereby consent, authorize, and request my periodontist Dr. Christine Gadia or Dr. Robert Busan to perform certain remedial measures including by not limited to one or more of the following procedures:

- Osteoplasty and/or Osteectomy
 - Placement of osseous grafts
 - Gingivectomy and/or Gingivoplasty
 - Curettage
 - Crown lengthening
 - Removal of retained root tips or other foreign matter from the gingival and/or alveolar bone.
 - Any other procedures, which the doctor has deemed necessary and after is has been fully explained to me.
- Frenectomy
 - Extraction of Indicated teeth
 - Exostosis removal
 - Membrane Placement
 - Biopsy
- Distal Wedge procedure
 - Root reception
 - Use of Biologic Mediators
 - Wilkodontics

I understand that anesthetic and/or medication will be administered to me as part of the treatment which may be deemed advisable for the procedure. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

During this procedure, my gum will be thoroughly cleaned. Bone irregularities may be reshaped, and bone regenerative material may be placed around my teeth. These bone graft materials will be placed in areas of bone loss around the teeth. There are various types of bone graft materials that may include my own bone (autogenous), bone obtained from tissue banks (allografts), bone of bovine (calf) origin (xenograft), or may be synthetic bone substitutes. Membranes may be used with or without the grafting material depending on the bone defect. My gum will then be sutured back into position, and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for modification or change from the anticipated surgical plan. These may include, but are not limited to, (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all the surgery originally outlined, or (4) whatever is deemed advisable and necessary (surgical or non-surgical) under the circumstances, after being informed. Further, unless otherwise requested by me, consent to the disposal of any tissue, which may be removed to be examined by a pathologist (biopsy).

Expected Benefits. The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth. The use of bone, bone graft materials, or the placement of a membrane (resorbable or non-resorbable) is intended to enhance bone and gum healing.

Principal Risks and Complications. Any surgical interference carries certain risks and complications that may arise. I understand that some patients do not respond successfully to any type of surgical operation or periodontal treatment, and in such cases, the involved teeth may eventually be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding or hematoma (blood clot), separation of the wound, extrusion and/or movement of the bone graft material and/or membrane, swelling and pain, facial discoloration, 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 acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth, thus altering the aesthetic appearance (gingival recession with root exposure) and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. In the event that bone graft material is donated tissue; the tissue should have been tested for infectious disease. Nevertheless, these are a remote possibility that tests will not determine the presence of disease in a particular donor tissue. The exact duration of any complications cannot be determined and may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second and or additional procedure if the initial 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 of 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 this surgical procedure. I understand that my diligences in providing the personal daily care recommended by my periodontist and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives To Suggested Treatment. I understand that alternatives to periodontal surgery include: (1) no treatment with the expectation of possible advancement of my condition which may result in premature tooth loss; (2) extraction of teeth involved with periodontal disease and (3) non-surgical scraping of roots and lining of the gum (scaling and root planning), with or without medication, in an attempt further to reduce bacteria and tartar, may not reduce gum, pockets, will require more frequent professional care and time commitment, and may not arrest the worsening of my condition and the premature loss of teeth.

Necessary Follow-Up Care And Self-Care. I understand that it is important for me to continue to see my regular dentist and maintain diligent and consistent home and professional care. Existing restorative dentistry can be an important factor in the success of failure of periodontal therapy. From time to time, my periodontist may make recommendations for the placement of restorations, the replacement or modification of restorations, the joining together of two or more of my teeth, the extraction of one or more teeth, the performance of root canal therapy, or the movement of one, several or all of my teeth. 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 their artificial replacements 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 my 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 adjustments of prosthetic appliances.

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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 benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. 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.

Wilkodontics (Periodontal Surgical Part of the Accelerated Osteogenic Orthodontic Procedure). The Wilkodontics procedure is performed to permit the movement of teeth in a more rapid and safe manner. The movement of the roots of the teeth may require the use of bone grafting material (allograft-cadaver or xenograft-bovine), membrane material, and/or in combination with gingival grafting procedures. I understand that this procedure will be performed around the teeth that have been specified by Dr. Christine Gadia and/or Dr. Robert Busan and I have discussed the procedure in its entirety and understand that it will be performed in conjunction with orthodontic treatment. Alternatives and risks have been fully discussed and I have fully understood and read completely the patient information BOOK that was given to me prior to the start of the treatment today. I understand that the Wilkodontics procedure may lessen the likelihood of severe gum recession in certain cases, but will not eliminate any possibility of gum recession in the future. I understand that Wilkodontics system will not decrease the likelihood of papillary shrinkage between the teeth and I understand that this may occur even after the Wilkodontics system is performed. Alternatives discussed may include, but not limited to, orthognathic surgery to reposition the jaw, conventional orthodontic treatment as well as no treatment at all.

PATIENT CONSENT

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatment 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, and other course of treatment, as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures that may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

X _____
PAGE 2 of 2 INFORMED CONSENT FOR PERIDONTAL TREATMENT AND SURGERY - PATIENT, PARENT or GUARDIAN SIGNATURE PAGE 2 of 2 - DATE

X _____
SIGNATURE OF WITNESS FROM - MILLENNIUM PERIODONTICS DATE