MILLENNIUM PERIODONTICS - CONSENT FOR GINGIVAL/RIDGE AUGMENTATION PROCEDURES

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 – significant gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gum line or crowns with edges under the gum line, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

RECOMMENDED TREATMENT: In order to treat this condition, I hereby consent, authorize and request Dr. Christine Gadia or Dr. Robert Busan to perform certain remedial measures including but not limited to one or more of the following ridge augmentations or associated procedure:

Gingival Grafts (Free Gingival or Connective Tissue)
Ridge Augmentation
Frenectomy
Pedicle Autografts
Subepithelial Connective Tissue Grafts
Coronally Displaced Flap
Use of Dontated Human Tissue for Graft
(a cellular dermal matrix)
Use of Biologic Mediators

These procedures will be performed in areas of my mouth with gum recession and or ridge deficiencies. 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. This surgical procedure involves the transplanting of a thin strip of gum from elsewhere in my mouth or the use of donated tissue. The transplanted strip of gum or donated tissue can be placed at the base of the remaining gum, or it can be placed so as to partially cover the tooth root surface exposed by the recession. A Periodontal bandage or dressing may be placed.

EXPECTED BENEFIT; The purpose of ridge augmentation and/or associated procedures is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surface, to enhance the appearance and/or dimensions of the ridge, the teeth and gum line, or to prevent or treat root sensitivity or root decay.

PRINICPAL RISKS AND COMPLICATIONS: Any surgical interference carries certain risks and complications that may arise. I understand that a small number of patients do not respond successfully to ridge augmentation. If a transplant is placed, so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during the healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession or with increased spacing between the teeth.

I understand that complications may result from ridge augmentation or from anesthetics or medications administered. These complications include, but are not limited to (1) post-surgical infection, (2) bleeding, hematoma (blood clot) formation, separation of the wound or graft material, swelling and pain, (3) facial discoloration, (4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet, or acidic foods, (5) allergic reactions, and (6) accidental swallowing of foreign matter, (7)transient but on occasion permanent numbness of the jaw, lip, tongue, teeth or chin. The exact duration of any complications cannot be determined and they 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 procedure if the initial surgery is not satisfactory. IN addition, the success of ridge augmentation can be affected by (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) alcohol consumption, (5) clenching and grinding of the teeth, (6) inadequate oral hygiene, and (7) medications that I may be taking. To my knowledge I have reported to the 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 prescribed medications are important to the ultimate success of the procedure.

ALTERNATIVES TO SUGGESTED TREATMENT. My periodontist has explained alternative treatments for my gum recessions, and modification of technique for brushing my teeth.

NECESSARY FOLLOW-UP CARE AND SELF CARE. I UNDERSTAND THAT IT IS IMPORTANT FOR ME TO CONTINUE TO SEE MY REGULAR DENTIST. Existing restorative dentistry can be an important factor in the success of failure of ridge augmentation.

I recognize that natural teeth and their artificial replacements should be maintained daily in a lean, hygienic manner. I will need to come to appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of 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 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 benefit in reducing the cause of my condition and should produce healing which will hlp me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. The 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.

PATIENT CONSENT. I have been fully informed of the nature of ridge augmentation surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available and the necessity for follow up and self-care. I have had an opportunity to ask any question I have had in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of ridge augmentation surgery, and any other cause of treatment, as presented to me during the consultation and in the treatment plan presentation as described in the 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 Signature Date

Witness Signature Date