SAEID MALBOUBI D.D.S.MS
Periodontist , Implant and oral plastic surgeon

CONSENT FOR GINGIVAL AUGMENTATION SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that I have 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 gum line, it is important to have sufficient width of attached gum to withstand the irrigation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect root of the teeth.

Recommended Treatment: In order to treat this condition, my periodontist has recommended the gingival augmentation (gum grafting) procedures be performed in areas of my mouth with significant gum recession. I understand that sedation may be utilized and a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplantinfg of a thin strip of gum form elsewhere in my mouth. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed to partially cover the root tooth surface exposed by the recession. A periodontal bandage or dressing may be placed.

Expected Benefits: The purpose of gingival augmentation is to create an amount of attached gum tissue adequate to reduce the likely hood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, or to prevent or treat root sensitivity or root decay

Principal Risks and Complications: I understand that a small number of patients do not respond successfully to gingival augmentation. If a transplant is placed to partially cover root surface exposed by the recession, the gum placed over the root may shrink back during 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 gingival augmentation or anesthetic. These complications include, but are not limited to (1) post surgical infection, (2) bleeding, swelling, and pain, (3) facial discoloration, (4) transient or on occasion permanent teeth sensitivity to hot, cold, sweet or acidic food, (5) allergic reactions, (6) accidental swelling of foreign matter. The exact duration of any complication cannot be determined and there 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 procedure is not

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satisfactory. In addition, the success of gingival augmentation can be affected by (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) alcohol consumption, (5) clenching or grinding of 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, aallergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications is important to the ultimate success of the procedure.

Alternative to Suggested Treatment: My periodontist has explained alternative treatments for my gum recession. These include no treatment, continued monitoring for progressive recession, 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 gingival augmentation.

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 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 preventive 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 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.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and

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reimbursement purposes. My identity will not be revealed to the general public however, without my permission.

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PATIENT CONSENT

I have been fully informed of the nature of gingival augmentation surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity of follow-up and self care. I have had an opportunity to ask any questions I may have in connection with treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of gingival augmentation 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 each 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

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DATE PRINT NAME OF PATIENT

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SIGNATURE OF PATIENT

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DATE PRINT NAME OF DOCTOR

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SIGNATURE OF DOCTOR

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DATE PRINT NAME OF WITNESS

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SIGNATURE OF WITNESS