DENVER PERIODONTICS & IMPLANT DENTISTRY

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CONSENT FOR GINGIVAL GRAFTING SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, my doctor at DPID has advised me that I have gum recession requiring treatment, or areas predisposed to gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gumline or crowns with edges under the gumline or for orthodontic therapy, it is important to have sufficient width of attached gum to withstand the irritation caused by these restorations or procedures. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

Recommended Treatment: In order to treat this condition, my doctor has recommended gingival grafting procedures to be performed with the use of local anesthesia, and possibly also oral sedation. Transplanted tissue will be placed to partially or completely cover the tooth root surface exposed by the recession, or to simply thicken the gum tissue if the goal of the graft is to prevent recession from occurring. The transplanted tissue may be either tissue from my palate or other area of the mouth. Alternatively, I have the option of using "allograft" material, or gum graft material obtained from a tissue bank for use in my graft procedure. I understand that this graft material may be of human or animal tissue, and I understand that it is an alternative to the use of my own tissue.

I also understand that my doctor will look at my occlusion (my bite) to determine if adjustments to the bite are necessary. I also understand that my doctor Heather Richardson DMD MS may make adjustments to my bite in an attempt to reduce any trauma to the tooth (teeth) involved in the surgical procedure. I understand that my doctor may suggest an occlusal guard (night guard) to help protect my teeth and the gum and bone supporting the teeth.

Expected Benefits: The purpose of gingival grafting is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Other purposes for this procedure are to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, and to prevent or treat sensitivity or root decay.

Principal Risks and Complications: I understand that no guarantees of success can be or have been made, and that a patient may not respond successfully to gingival grafting. If a transplant is placed to cover the tooth root surface exposed by the recession, the tissue placed over root may shrink back during healing. If this occurs, the coverage of the exposed root surface may not be complete and may require a secondary procedure if additional root coverage is needed. I understand that in order to gain root coverage my doctor may have to remove some of the existing restorative (filling) material at the gum line in order to improve the chances of gaining root coverage.

I understand that complications may result from any surgery and/or from simply administering local anesthetics. These complications include, but are not limited to: (1) bleeding, swelling, and pain; (2) facial discoloration; (3) post surgical infection; (4) transient or, on occasion, permanent tooth sensitivity to hot, cold, sweet or acidic foods. Less-common side effects may include: (1) numbness of the jaw, lip, tongue, teeth, chin or gum which are usually transient but on rare occasions can be permanent; (2) jaw joint muscle spasm; (3) transient or, on occasion, permanent increased tooth looseness; (4) allergic reactions.

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 gingival grafting can be affected by: (1) trauma to the healing graft; (2) smoking; (3) medical condition; (4) excessive alcohol consumption;

and (7) medications that I may be taking. To my knowledge I have reported to my doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might be related to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by Heather Richardson DMD MS, and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: My doctor Heather Richardson DMD MS 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 recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to come for post-surgical appointments following my surgery so that my healing may be monitored and so that my doctor Heather Richardson DMD MS can evaluate and report on the outcome of surgery upon completion of healing. I further understand that long-term success requires my long-term continued performance of daily plaque removal and my return for periodic professional maintenance therapy.

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

I have been fully informed of the nature of gingival grafting surgery, the procedure to be utilized, the risks and benefits of such surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had the opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my doctor Heather Richardson DMD MS. After careful consideration, I hereby consent to the performance of gingival grafting surgery as presented to me. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my doctor Heather Richardson DMD MS.

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

_____ _____

Patient's (or Legal Guardian's) Signature Date

_____ _____

Witness' Signature Date