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CONSENT FOR GUM GRAFT SURGERY

PATIENT NAME: _____

Diagnosis: Teeth are surrounded by two types of tissue, gingival and mucosa. Mucosa is cheek like tissue, and does not adhere to the roots of the teeth or underlying jaw bone very well, as compared to gingival, which is more fibrous tissue. Mucosa, at the gum line of the tooth/teeth or as the only gum tissue that is adhering to the roots of the tooth/teeth is much more likely to recede, causing more root of the tooth to show and causing a loss of the underlying jawbone around the tooth/teeth. Having a good amount of jawbone around the tooth/teeth is essential, as it is the jawbone that holds the tooth/teeth in place. The gum just covers it over.

After a careful oral examination, radiographic evaluation and study of my dental condition the Dentist has advised me that I have an insufficient amount of attached gingival (firm gum tissue) around my tooth/teeth. I understand with this condition gum recession may occur. In addition, for fillings or crowns with edges under the gum line, it is important to have sufficient width of firm, adhered gingival to the roots of the tooth/teeth to withstand the irritation they may cause. Gingiva also improves the appearance and protects the roots of the tooth/teeth.

Recommended Treatment: The Dentist has recommended that Gum Graft Surgery be preformed in some areas of my mouth. Local anesthetic (commonly called Novocain) will be administered as part of my surgery. Gum grafting involves the excision (removal) of a thin strip of gingival from the palate (roof of the mouth) to be transplanted in the donor site, then sutures will be placed on the palate. The existing gum tissue around the teeth to be grafted will be excised back, and the transplanted gingival from the palate will be sutured in place and existing gum tissue sutured over the graft tissue. About 1/3 of the time, generally 3-4 weeks after the graft is done, it is necessary to "refine" the area like a scar revision.

Expected Benefits: The purpose of Gum Graft Surgery is to create an amount of attached gum tissue adequate to reduce the likelihood of gum recession. It is also hoped to cover back up some of the exposed root(s) of the tooth/teeth.
***Do not expect the entire exposed tooth root caused by existing gum recession to be totally recovered with this surgery. That may not happen.*

Principal Risks and Complications: A small number of patients (usually around 5%) do not have the graft "take". The usual causes are excessive shrinking of the graft tissue while healing the first couple of weeks, smoking, or the patient knocking the graft loose during the first week. So it might be necessary to do the graft over again after about three months to allow the surgical sites to heal up first. Usually, but not always a second graft will "take".

Sometimes complications may result from the gingival graft or from anesthetics or drugs. These complication include but are not limited to post-surgical infection, bleeding swelling, pain, facial bruising, transient (on rare occasion permanent) numbness of the jaw, lip, tongue, chin or gum, jaw joint pain or muscle spasm, 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, accidental swallowing of foreign matter, transient (on rare occasion permanent) tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods. The exact duration of any complication cannot be determined, and may be irreversible.

Alternatives to Suggested Treatment: Alternatives to gum Graft Surgery include:

1. No treatment-The likelihood of gum recession and subsequent jawbone loss around the tooth/teeth is higher with no gum graft than with a successful gum graft. There are studies that show the incidence of tooth loss is six times greater in individuals with untreated gum problems as compared to early treatment of gum problems.

Necessary Follow-Up Care and Self Care: I fully understand it is important for me to see my dentist for routine dental care.

I acknowledge smoking may adversely affect gum healing and may limit the successful outcome of my surgery. Studies show smokers have more grafts that fail to "take" than non—smokers.

I know I should use soft bristly toothbrushes or soft electric toothbrushes (such as Sonicare®) forever. Good oral hygiene for the rest of my life is essential to good dental health.

I have told the dentist about any pertinent medical conditions I have, allergies (especially to medications or sulfites) or medication I am taking, including over the counter medications such as aspirin.

I acknowledge I will need to come back for several post-operative visits so my healing may be monitored and so the Dentist can evaluate the healing process. Smoking, excessive alcohol intake or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to healing and may limit the successful outcome of my surgery. I know that it is important to

1. Abide by the specific prescriptions and instructions given.
2. See the Dentist for post-operative visits as needed.
3. Quit smoking.

Patient Initial**____**

4. Perform excellent oral hygiene once instructed to, usually starting 4 weeks after the surgery is done.
5. Have the graft area reshaped, if needed, several months later, there is no extra charge for this.

No Warranty of Guarantee: While in most cases gum cases gum grafting is successful both in "taking" and preventing further gum recession from occurring; no guarantee, warranty or assurance has been given to me that the proposed gum graft will be successful. Due to individual patient differences no one can predict certainty of success. There is a remote possibility of a worsening of my present condition, including the possible loss of certain teeth despite the best of care. No refunds will be given and further fees will be charged at a reduced rate for any re-treatments or corrective surgeries.

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 either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

Communication with my Insurance Company, My Dentist or other Dental/Medical Providers involved with my care: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, dentist's billing agency, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Adverse Reaction to Medications: Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol, or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of the same.

Procedure(s) to be preformed:

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***Patient Initial*_____**

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the Dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking, I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the Dentist. I understand Dr. Sam Patel is a general dentist and I have declined a referral to a specialist for this procedure. I have read and understand this document before I signed it.

_____ _____

Signature of patient, parent or guardian Print Name

_____

Signature of Dentist

_____

Date