PERIODONTAL SURGERY

I hereby authorize the doctor and staff to perform upon me the following procedure(s) as indicated below:

-**Esthetic Crown Lengthening Surgery:** to improve esthetics & cleansibility by reshaping gum and bone tissue around teeth

-Functional Crown Lengthening Surgery: to restore a broken down tooth by reshaping gum and bone tissue around teeth

-Gingivectomy/Gingival Recontouring: to improve esthetics & cleansibility by reshaping gum tissue

-Soft Tissue Grafting/Mucogingival Surgery: to improve the esthetics of the gums, cover exposed root surfaces, or to provide more suitable gum tissue around teeth by transplanting donor tissue

-Hard Tissue Grafting/Osseous Surgery: to correct bony defects and/or promote new bone growth by reshaping and augmenting the hard tissue

-Open Flap Debridement: to remove disease by reflecting back the gum tissue and debriding bacteria from the root surfaces

-Distal Wedge Procedure: to improve cleansibility and improve pocket depth by removing gum tissue

-Frenectomy: to prevent gum recession, improve speech, or close spaces between teeth by reshaping the frenum

I understand that I have a form of periodontal disease or a periodontal condition that has caused damage to the soft tissues and/or bone around my teeth. This disease or condition, if left untreated, is generally non-reversible and can be progressive, eventually leading to further damage and possible loss of my teeth.

I also understand that a variety of surgical procedures are used to treat periodontal disease. While these surgical treatments are generally successful, I understand that no guarantee, warranty, or assurance has been given that the proposed surgical treatment will be curative and/or successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present condition may result despite the treatment.

It has been explained to me that long-term success of treatment requires my cooperation and performance of effective plaque control (home care) on a daily basis and periodic periodontal maintenance visits at a dental office after the proposed surgical treatment performed.

I further understand that if no treatment is rendered, my present periodontal condition has the potential to worsen with time and may result in premature tooth loss.

I have been informed that other possible alternative methods of treatment may exist.

Although significant complications from periodontal surgery are rare, they can occur and may include the following:

- Intra-surgical: bleeding, perforation of sinus membranes, temporary or permanent nerve damage, damage to adjacent teeth, crowns, or bridges.

- Post-surgical: bleeding, swelling, infection, bruising, discomfort, tooth sensitivity, tooth looseness, gum recession (shrinkage) creating open spaces between the teeth making teeth appears longer, numbness or altered sensation, exposure of crown margins, food lodging between teeth after meals, limited jaw opening or jaw discomfort, stretching of the corner of the mouth.

I realize that by not revealing complete, truthful information about my past medical history, medication, drug use, possible pregnancy, etc, I place myself under significant risk for the surgical procedure and anesthesia. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injuries and current medications with the doctor.

I certify that I have fully read and understand the above consent to the surgical treatment, the explanation therein referred to or made, before I signed this document. I have had my questions answered. I recognize there can be no warranty as to the outcome of treatment and I give my consent to surgery.