CONSENT FOR PERIODONTAL FLAP SURGERY

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An explanation of your need for periodontal flap surgery, the procedure and the postoperative benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo the treatment planned for you. Please read this document which repeats issues we discussed in their entirety and provide the appropriate signatures on the last page. Please excuse us for this inconvenience and do ask us to clarify anything that you do not understand.

DIAGNOSIS: I have been informed of the presence of periodontal disease in my mouth and that this involves the weakening of the support to my teeth by first producing a separation of the gum in hard to clean areas and that this can result in my body's defense reactions or infection resulting in erosion or loss of bone supporting the roots of my teeth.

SUGGESTED TREATMENT: It has been suggested that my treatment include periodontal flap surgery.

PURPOSE OF PERIODONTAL FLAP SURGERY: I have been informed that the purpose of this procedure is to allow access for the cleaning of the roots of my teeth and the lining of the gum as well as to treat irregularities of the jaw bone surface so that when the gum is replaced about the teeth, it will allow for the reduction of pockets, infections and inflammation. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and of the ability of professionals to better clean my teeth of tartar and bacteria. The reduction of infection and inflammation should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated area (s).

ALTERNATIVES TO TREATMENT: These may include (1) no treatment with the expectations of the advancement of my condition resulting in the possible premature loss of teeth; (2) extraction of the teeth involved with periodontal disease; (3) attempts to further reduce bacteria and tartar under the gum line by non-surgical scrapings of tooth roots and lining of the gum (root planning and curettage) with the expectation that this will not fully eliminate deep bacteria and tartar, resulting in only a partial and temporary reduction and may result in the worsening of my condition and the premature loss of teeth.

RISKS RELATED TO THE SUGGESTED TREATMENT: Risks related to periodontal flap surgery might include but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, transient or on occasion, permanent tooth looseness; tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth. Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling and bruising, pain, soreness, or discoloration at the site of injection of the anesthetics.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurances have been given to me that the proposed surgery will be completely successful in eradicating pockets, infections, or further bone loss or gum recession. It is anticipated (hoped) that the surgery will provide

benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth, but due to individual patient differences, one cannot predict the absolute certainty of success. There-fore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement despite the best of care.

CONSENT TO UNFORESEEN CIRCUMSTANCES: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include but are not limited to extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multirooted tooth so as to preserve the tooth, the placement of bone graft material or the use of material to guide (or enhance) tissue regeneration, or termination of the procedure prior to the completion of all the surgery originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures and for their educational use is lectures and publications provided my identity not be revealed.

PATIENT ENDORSEMENTS: My endorsement (signature) to this form indicates that I have read and fully understood the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to periodontal flap surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document

_____ _____ _____

Patient's Signature (Legal Guardian) Date Relationship To Patient

_____ _____ _____

Signature Of Witness Date Patient Name

As part of this consent agreement, I give my personal pledge, as a health care professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.

_____ _____

Signature Of Doctor Date