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CONSENT FOR PREPROSTHETIC PERIODONTAL SURGERY

DIAGNOSIS: In consultation with my dentist (generalist, endodontist or prosthodontist) it has been determined that there is not enough tooth structure protruding above the gumline for further therapy to be attempted. This can prevent adequate isolation of the tooth (or teeth) in question for root canal treatment or access for restorative therapy (filling, bonding or full crown).

RECOMMENDED TREATMENT: In order to treat this condition, my doctor has recommended that my treatment include pre-prosthetic periodontal surgery. I understand that a local anesthetic will be administered to me as part of the treatment. During this procedure, some of my gum will be removed to allow more of the tooth to be exposed above the gumline. Also, my gum may be opened to permit access for reshaping and removing small amounts of bone to further improve the prognosis for subsequent endodontic or restorative treatment. My gum will then be sutured back into position, and a periodontal bandage or dressing may be placed. However, unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, (1) extraction of hopeless teeth, (2) the necessity to do as much as possible to expose the tooth in a proper manner without permanently compromising tooth support, or (3) risk-benefit ratio with respect to potential exposure of vulnerable root areas (furcations).

EXPECTED BENEFITS: The purpose of this periodontal surgery is to provide a more favorable environment for subsequent therapy. This may include endodontic therapy (root canal) or restorative treatment (fillings, veneers, crowns or bridges/fixed partial dentures or removable partial dentures).

PRINCIPAL RISKS AND/OR COMPLICATIONS: I understand that occasionally complications may result from the pre-prosthetic periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm. Additionally, possible, most often to be transient but on occasion, permanent increased tooth looseness, damage to adjacent dental restorations (fillings or crowns), tooth sensitivity to hot, cold, sweet or acidic foods, involvement of the nerve of the tooth which may require a root canal, perforation of the maxillary sinus, perforation or shrinkage of the gum upon healing resulting in the appearance that some teeth are elongated. 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 results are not satisfactory. In addition, the success of periodontal procedures can be affected by my medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To the best of my knowledge, I have reported to my doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to the surgical procedure. I understand that my diligence in providing the personal daily care recommended by my doctor and taking all prescribed medications are important to the ultimate success of the procedure.

ALTERNATIVE TO SUGGESTED TREATMENT: I understand that alternatives to periodontal surgery include (1) no treatment - with the expectation that further treatment on the tooth (or teeth) in question cannot be performed or the prognosis of the tooth (or teeth) is greatly reduced if no treatment is attempted or (2) extraction of tooth (or teeth) involved and the generation of a new treatment plan.

NECESSARY FOLLOW-UP CARE AND SELF-CARE: I understand that it is important for me to continue to see my regular dentist (generalist or prosthodontist) to continue the proposed treatment in the proper sequence and in a timely manner is critical. I understand that the failure to follow such recommendation could lead to ill effects, which would become my sole responsibility. I understand I will need to come for appointments following my surgery so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of surgery upon completion of healing. I know that it is important to (1) abide by the specific prescriptions and instructions given by the doctor, and (2) see my dentist for periodic examination and preventive treatment.

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 result in an improved situation for the additional therapy which is planned (root canal, prosthetics) for the tooth (teeth) in question. Due to individual patient differences, however, a doctor 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.

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I have been fully informed of the nature of pre-prosthetic periodontal surgery, the procedure to be utilized, the risks and benefits of pre-prosthetic periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my doctor. I hereby consent to the performance of pre-prosthetic periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document.

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

SIGNATURE OF PATIENT **DATE**

I certify that the matters set forth above were explained fully to the patient, that the patient was given an opportunity to ask questions, that all questions asked were answered in a satisfactory manner, and that all the blanks in this form were filled in prior to signature by the patient. Where this form has been signed by the patient rather than his/her representative, I certify that, in my judgement, the patient was competent to understand the matters discussed and to give his/her consent to treatment.

SIGNATURE OF DENTAL SURGEON **DATE**