WILLIAM E. MASON, D.D.S., M.S.
MONICA A. LAMBLE, D.D.S., M.S.
PERIODONTICS & DENTAL IMPLANTS

205 Colony Drive North
Saginaw, Michigan 48638

WEB www.doctormasononline.com **TELEPHONE** (989) 792-4431 **FAX** (989) 792-4387

CONSENT FOR PERIODONTAL SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, my doctor has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further erosion or loss of bone and gums supporting the teeth. If untreated, periodontal disease can cause me to lose my teeth and have other adverse consequences.

Recommended Treatment: In order to treat this condition, my doctor has recommended that my treatment include periodontal surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

___ Crown Lengthening/Gingivectomy: During this procedure, my gums will be opened to permit better access to the roots and bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. In order to gain greater tooth length, some bone and/or gum will be removed around the tooth or teeth to be lengthened as well as the adjacent teeth and any bone irregularities may be reshaped. My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

___Recommended Extractions: In order to treat this condition, my doctor has recommended that my treatment include extraction(s) of my tooth (teeth). I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment.

___ Osseous Surgery: During this procedure, my gums will be opened to permit better access to the roots and bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped. My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

___Bone Regenerative Surgery: During this procedure, my gum will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Various types of graft materials may be used, these may include; my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Membranes may be used with or without graft material – depending on the type of bone defect present. My gum will be sutured back into position, and a periodontal bandage or dressing may be placed.

___ Subepithelial Connective Tissue Grafting: This surgical procedure involves taking connective tissue obtained from the palate or using Alloderm (an acellular dermal matrix) and securing it over the root surface(s) exposed by recession and covering it with the remaining gum. My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

___ Frenectomy: This procedure has been recommended to reduce and relieve a web of tissue, the frenum which is pulling on the adjacent gingiva. A frenum may be unaesthetic, make gingival recession worse, interfere with healing of a subepithelial connective tissue graft or keep teeth from staying together after orthodontics. The frenum is removed and the tissue sutured together, a periodontal bandage or dressing may be placed.

___ Biopsy: This procedure has been recommended to remove all or some of the tissue which has been judged to be abnormal in nature. The area will be sutured following the procedure. This tissue will be submitted to an oral pathologist for microscopic evaluation.

I understand that unforeseen conditions may call for a modification or change from anticipated surgical plan. These may include, but are not limited to, **(1)** extraction of hopeless teeth to enhance healing of adjacent teeth **(2)** the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or **(3)** termination of the procedure prior to completion of all of the surgery originally outlined.

Expected Benefits: The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

Principal Risks and Complications: I understand that a small number of patients do not respond successfully to periodontal surgery, and in such cases, the involved teeth may be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the 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, transient but on occasion permanently increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, 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, and accidental swallowing of foreign material. The exact duration of any complications cannot be determined and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will feel. 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 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 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 this 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.

Alternatives To Suggested Treatment: I understand that alternatives to periodontal surgery include: **(1)** no treatment, with the expectation of possible advancement of my condition, which may result in premature loss of teeth **(2)** extraction of teeth involved with periodontal disease **(3)** non-surgical scraping of tooth roots and lining of the gum (scaling and root planing and curettage), with or without medication, in attempt to further reduce bacteria and tartar under the gum line, with the expectation that this may not fully eliminate deep bacteria and tarter, may not reduce gum pockets, will require more frequent professional care and time commitment, and may result in the worsening or my condition and premature loss of teeth.

Necessary Follow-up and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my doctor may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the extraction of one or more teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. 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. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important **(1)** to abide by the specific prescriptions and instructions given by the doctor and **(2)** to see my doctor for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that proposed treatment would be successful. In most cases, the treatment should prove to be a benefit in reducing the cause of my condition and should result in healing, which will help me keep my teeth. 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.

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 the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Patient Consent: I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of 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. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my doctor.

***PLEASE LIST ALL MEDICATIONS/DRUGS TAKEN IN THE LAST 24 HOURS.**

_____

_____

Yes☐ No☐ If you are a female and taking birth control pills: By signing below I certify that when taking an antibiotic, I must use other forms of birth control for up to one month after finishing the antibiotic.

Yes ☐ No☐ If you have taken or are taking bisphosphonate medications: By signing below I certify that I have been informed of and accept any risks I may have due to the use of these drugs.

Yes☐ No☐ If you are a regular blood donor or plan to donate in the future please be aware that donor agencies may not accept your blood if you have bone grafting material placed during this procedure. (Please inform us of your future plans)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

___/___/___ _____
Date Print Name and Signature of Patient, Parent, or Guardian

___/___/___ _____ ___/___/___ _____
Date Printed Name and Signature of Witness Date Dr. William E. Mason/Monica A. Lamble