NATURAL SMILES

General & Implant Dentistry

INFORMED CONSENT FOR GINGIVAL GRAFTING PROCEDURE

GEORGIA STATE LAW REQUIRES THAT WE OBTAIN YOUR CONSENT PRIOR TO THIS SURGICAL PROCEDURE

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

REQUEST AND INFORMED CONSENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

Patient's Name:

Date:

The following has been explained to me in general terms and I understand that:

(1) **The diagnosis requiring this procedure is gum recession or areas predisposed to gum recession.**

(2) **The nature of the procedure is surgical gingival grafting procedure. Transplanted tissue will be placed to partially or completely cover the tooth surface exposed by the recession. The transplanted tissue is received from the donor site usually located in the palate and alternative tissue may be used such as Alloderm or an acellular dermal matrix from the tissue bank.**

(3) **The purpose of the procedure is to gain additional sufficient width of attached gum to withstand the irritation caused by tooth brushing, orthodontic treatment or dental restorations that have margins close to the gum line.**

(4) **The likelihood of success of the above procedure is:**
( ) Good ( ) fair ( ) poor

(5) **Practical alternatives to this procedure are not doing a tissue graft, monitoring tissue for progressive recession and modification of tooth brushing techniques.**

(6) **If I choose not to have the above procedure, my prognosis (future medical condition) is further gum recession, exposure of root surfaces, sensitivity and decay of roots.**

(7) **Material risks of this procedure:**

Procedure will be done with nitrous oxide sedation and local anesthetic. If the procedure was being performed under general anesthesia: (I.V. sedation) there may be material risks of INFECTION, LOSS OF FUNCTION OR OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.

In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:

- **(a) Injury to the nerve resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue. This may persist for several weeks, months or be permanent.**
- **(b) Post-operative discomfort and swelling that may necessitate several days of home recuperation.**
- **(c) The tissue transplanted over the roots may shrink while healing, exposing the root surface.**
- **(d) Stretching of the corners of the mouth with resultant cracking and bruising**
- **(e) Restricted mouth opening for several days or weeks**
- **(f) Bleeding, swelling and pain**
- **(g) Postoperative infection may occur requiring additional treatment.**
- **(h) Transient or, on occasion, permanent increased sensitivity of teeth to hot, cold, sweet or acidic food.**

I understand that the medical/dental personnel and others will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure, which has been explained.

I understand that the practice of dentistry and medicine are not exact sciences and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described, it may be necessary or appropriate to perform additional procedures which may not be known to be needed at the time this consent is given. I authorize the persons described herein to make decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as may be deemed necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations, and other treatment or courses of treatment relating to the diagnoses or procedures described herein.

I also consent that any tissues or specimens removed from my body in the course of any procedures may be tested for scientific purposes and then disposed of within the discretion of the physician, facility, or other health care provider.

I understand that certain medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which may be increased by the use of alcohol or other drugs. Thus I have been advised not to drive or operate hazardous equipment or work while taking medications and/or drugs until I have fully recovered from the effects. I understand and agree that if I have been sedated or given general anesthesia, I will not operate any vehicle or hazardous device for 24 hours after my release from surgery. I agree not to drive myself home after surgery and will have a responsible adult drive me home after being discharged from surgery.

Female patients: Research indicates that the reliability of oral contraceptives can be significantly diminished with the use of some antibiotics and other medications which may be used during the course of treatment. Alternative or additional forms of birth control should be used until the course of antibiotics or prescribed medication is completed.

I understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible dentist/surgeon, all medical-dental personnel under direct supervision and control of the responsible dentist/surgeon and for any medical/dental personnel otherwise involved in the course of treatment.

I understand that smoking, alcohol and sugar intake may adversely effect healing and increase the likelihood of postoperative infections which may limit the success and prognosis of the surgery and future treatment performed. I agree not to smoke for two weeks prior to surgery and not to smoke following surgery.

I understand that the success of the gingival grafting can be affected by trauma to the healing graft, clenching or grinding of teeth, dietary and nutritional problems, and alcohol consumption. To my knowledge I have reported to my dentist any prior drug reaction, allergies, diseases, symptoms, habits, or conditions which might in any way relate to the surgical procedure.

I understand that I am responsible for following the post-operative instructions given to me following the surgical procedure. I will need to come in for appointments following gum surgery so my healing may be monitored and so that my dentist can evaluate the outcome of the surgery upon completion of healing.

Due to individual patient differences, a dentist cannot with certainty predict success. There is a risk of failure, relapse, need for additional treatment, or even worsening of my condition despite the best of care.

I consent to photographs, recordings, and x-rays of the procedure to be performed for the advancement of dentistry.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND IT'S CONSENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ALL QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKKS OR STATEMENTS I DO NOT APPROVE OF WEERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN. I HAVE HAD THE OPPORTUNITY TO EVALUATE THE CREDENTIALS AND EDUCATIONAL BACKGROUND OF TREATING DOCTORS.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Edward Mills, involved in the course of my treatment.

Person giving consent (patient or legal guardian)

Relationship to patient if not the patient:

Patient is unable to sign because of:

Witness

Doctor