FAIRFAX PERIODONTAL GROUP
PERIODONTICS AND DENTAL IMPLANTS

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Consent For Gingivectomy

Patient Name:___________________________________ Date:_____________________

GINGIVECTOMY: A gingivectomy is a type of surgery used to remove excessive tissue or to reduce periodontal pockets. It involves not only removal of the tissue, but scaling and root planing of the affected teeth. This procedure is performed with local anesthesia.

RISKS RELATED TO THE SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to gingivectomy surgery might include post-surgical infection, bleeding, bruising, swelling, or pain. Risks related to the anesthetics might include but are not limited to; allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthesia.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in reducing the interference with the normal alignment of the teeth or impingement on the gingiva (gums). It may need to be retreated. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition.

PATIENT'S ENDORSEMENT: My signature on this form indicates that I have read and fully understand 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 the Gingivectomy surgery as presented to me during the consultation by the doctor and treatment plan presentation by the office manager or as described in this document

Patient (or Legal Guardian) Signature:___________________________ Date:_____________

Dentist Signature:____ Date:_____________

Witness Signature:____ Date:_____________