FAIRFAX PERIODONTAL GROUP
PERIODONTICS AND DENTAL IMPLANTS

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Consent for Gingival Graft Surgery

Patient Name: _____ Date: _____

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have significant gum recession or areas predisposed to gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gum line or crowns with edges under the gum line and for orthodontic therapy, it is important to have sufficient width of attached gum to withstand the irritation caused by these restorations or procedures. Gum tissue may also be placed to improve appearance and to protect the roots of the teeth.

Recommended Treatment. In order to treat this condition, my periodontist has recommended gingival grafting procedure(s). I understand that a local anesthetic will be administered and sedation may be utilized to me as part of the treatment. Transplanted tissue will be placed to partially or completely cover the tooth root surface exposed by the recession. The transplanted tissue is AlloDerm, an acellular dermal matrix from a tissue bank. Occasionally palatal tissue may be used.

Expected Benefits. The primary purpose of gingival grafting is to increase the thickness of gum tissue to reduce the likelihood of further gum recession. Other purposes for this procedure are to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, and to prevent or treat sensitivity or root decay.

Principal Risks and Complications. I understand that occasionally the surgical outcome does not meet expectations. If a graft is placed to cover the tooth root surface exposed by the recession, the tissue placed over the root may shrink back during healing. If this occurs, the coverage of the exposed root surface may not be complete. Occasionally a secondary procedure may be performed if additional root coverage is needed.

I understand that complications may result from gingival grafting or from anesthetics. These complications include, but are not limited to: (1) bleeding, swelling and pain, (2) facial discoloration, (3) post-surgical infection, (4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods. Less common side effects include, but are not limited to (1) numbness of the jaw, lip, tongue, teeth, chin or gum, (2) jaw joint injuries or associated muscle spasm, (3) transient, but on occasion, permanent increased tooth looseness, (4) restricted ability to open the mouth for several days or weeks, (5) impact on speech, (6) allergic reactions, and (7) accidental swallowing of foreign matter. 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 heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of gingival grafting can be affected by: (1) trauma to the healing graft (2) smoking (3) medical conditions (4) clenching and grinding of the teeth (5) dietary and nutritional problems, (6) alcohol consumption, and (7) medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might, in any way, be related to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. My periodontist has explained alternative treatments for my gum recession. These include no treatment, continued monitoring for progressive recession and modification of technique for brushing my teeth.

Necessary Follow-up Care and Self-Care. I recognize that natural teeth and appliances should be maintained daily in a clean and hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. I further understand that long-term success requires my long-term continued performance of daily plaque removal and my return for periodic professional maintenance therapy.

No Warranty or Guarantee. I know the practice of dentistry is not an exact science and that reputable practitioners cannot guarantee results. 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 provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient difference however, a periodontist cannot predict certainty of success. There is risk of failure, relapse, additional treatment, or even worsening of my present condition, despite the best of care.

Publication of Records. I authorize photos, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry or dental insurance documentation. My identity will not be revealed to the general public, however, without my permission.

I have been fully informed of the nature of gingival grafting surgery, the procedure to be utilized, the risks and benefits of such 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 periodontist. After thorough deliberation, I hereby consent to the performance of gingival grafting 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 periodontist.

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

Patient Name: _____

Patient Signature: _____

Witness Signature: _____

Doctor Signature: _____

Date: _____