FAIRFAX PERIODONTAL GROUP
PERIODONTICS AND DENTAL IMPLANTS

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# Consent For Periodontal Surgery

Patient Name:_____ Date:_____

I hereby authorize the doctors at Fairfax Periodontal Group to perform the following surgical procedure:

_____

I understand I have a form of periodontal disease or condition that has caused damage to the soft tissues and/or bone around my teeth. This disease or condition, if left untreated, is generally non-reversible and can be progressive, eventually leading to further damage.

I also understand that a variety of surgical procedures are used to treat periodontal disease/periodontal conditions. While these surgical procedures are generally successful, I understand that no guarantee, warranty or assurance has been given to me that the proposed surgical treatment will be curative and/or successful to my complete satisfaction. A risk of failure, relapse or worsening of my present condition may result despite the treatment.

It has been explained to me that long-term success of treatment requires my cooperation and performance of effective plaque control (home care) on a daily basis and periodic periodontal maintenance or prophylaxis cleanings at a dental office after the proposed surgical treatment is performed.

I further understand that if no treatment is rendered, my present periodontal condition has the potential to worsen with time and may result in premature tooth loss.

Although significant complications from periodontal surgery are rare, they can occur and may include the following:

A. Intra-surgical: Bleeding, perforation of sinus membranes, nerve damage, etc.
B. Post-Surgical: Bleeding, swelling, infection, discomfort, tooth sensitivity, tooth looseness, gum recession, numbness or altered sensation, exposure of crown margins, etc.

I certify that I have fully read and understand the above consent to the surgical treatment/procedure. I understand that my signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia:

Patient (or Legal Guardian) Signature:_____ Date:_____

Dentist Signature:_____ Date:_____

Witness Signature:_____ Date:_____