CONSENT TO TREATMENT - APF with OSSEOUS SURGERY & GTR

Name _____

1. I authorize Dr._____ to perform the following recommended dental treatment.

2. I understand that I have been diagnosed with the following problem(s):
    a. Periodontitis (localized or generalized) and bone defect.
    b. Pocket deep with no access for cleaning by the patient and hard to access for hygienists.

3. I understand that the following treatments are recommended (with prognosis):
    a. Apically position flap procedure with Osseous Surgery on teeth _____ _____ that involves reflection of soft tissue flaps for access, scaling and root planning of the tooth accompanied by soft and hard tissue (bone) recontouring under local anesthetic.
        i. Prognosis: **Good/ Guarded** because of furcation of lack of keratinized tissue.
    b. Guided tissue regeneration **area** _____ that involves addition of bone _____and membrane _____to try to regrow bone.
        i. Prognosis: **Good/ Guarded** because of anatomy of the defect, _____
    c. This procedure can also be conducted under **oral sedation or intra-venous** conscious sedation.
    d. This treatment may include the use of local anesthetic, antibiotics, analgesics, sutures (stitches) and a wound dressing if required.

4. I was also informed of the following alternate treatments (with prognosis):
    a. No surgery and 3 months hygiene with freezing.
        i. Prognosis: Reserve, risk of progression, risk of losing teeth over time and continued bone loss due to chronic inflammation, with limited access for cleaning.

5. The anticipated length of treatment, although I realize that it may vary greatly between patients and may be influenced by my own level of cooperation and participation and the availability of clinical appointments, and may be delayed by unforeseeable clinical and technical setbacks, has been explained as follows:
    a. Surgery time: _____
    b. Removing suture: 7,14, 21 days after surgery 15 min apt
    c. Follow up within 3 months: periodontal maintenance and reevaluation

6. I understand that risks related to the recommended treatments may include, but are not limited to the following:
    a. Allergic reactions to any dental products, materials and medications
    b. Bleeding
    c. Swelling and/or infection
    d. Pain and/or dentinal hypersensitivity
    e. Exposure of the root surface (recession)
    f. Exposure of gaps between the teeth
    g. Exposure of crown and bridge joints
    h. Temporary restriction of mouth opening
    i. Increase tooth mobility
    j. Possible paresthesia of dental nerves (teeth, lips, tongue, cheeks, palate…)

7. I understand that refusing treatment of my condition may impact on my oral and general health. Consequences may include but are not limited to:
    a. Progression of loss of bone support around tooth/teeth
    b. Increase in pocket depths around tooth/teeth
    c. Periodontal abscess
    d. Increase in tooth mobility
    e. Tooth migration
    f. Increase in gingival recessions
    g. Premature loss of tooth/teeth

8. I understand the necessity of maintaining a good oral hygiene for a better healing and the importance post-surgical appointments. I also understand the importance to strictly follow my periodontist's recommendations. Tobacco and alcohol products may affect healing negatively after periodontal surgeries and may also affect maintenance of surgical results.

9. I understand that I have been given no warranty nor guarantee pertaining to the success of suggested treatment. In most cases the suggested treatment should reduce causes of my periodontal condition and may permit me to keep my teeth for a longer period of time. Because of variations with patients' home self-oral care and medical health, the periodontist cannot positively predict the success of provided treatments. Even with optimal treatments, there are always risks of failure which may require re-treatment. The risks of degeneration of my periodontal condition may be still present and may lead to loss of teeth.

10. I authorize the use of photography, radiography and/or any other documentation, which pertains to care and treatment that I received, to be used for promoting advancement in dentistry. However, my identity will never be shown or discussed to public without my written consent.

11. **I CERTIFY THAT I COMPLETELY READ THIS DOCUMENT AND THAT ALL MY QUESTIONS WHERE PROVIDED WITH COMPREHENSIVE ANSWERS BEFORE SIGNING THIS DOCUMENT.**

_____ _____

(Signature and Date) (Doctor)