**Informed Consent for the Soft Tissue Grafting**

**Diagnosis**: Gum recession or areas predisposed to recession on the following tooth/teeth
_____

**Purpose of Soft Tissue Grafting:** I have been informed that the purpose of soft tissue grafting is to create an amount of attached gum tissue (protective tissue) adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of teeth and gumline, or to prevent or treat root sensitivity or root decay.

**Alternative Treatment:** The following alternatives to soft tissue grafting have been explained to me:
- No treatment.
- Continued monitoring for progressive recession and possible modification of brushing technique.

**Surgical Procedures may involve some, or all, of the following:**
- Use of local anesthetic, oral or intravenous sedation, antibiotics, analgesics and sutures (stitches).
- Use of donor tissue or resorbable membranes.

**Risks and Complications of soft tissue grafting:** I understand that the risks and complications include, but are not limited to:
- Allergic reactions to dental materials/medications,
- Bleeding, swelling, infection,
- Pain ,
- Temporary or permanent tooth sensitivity,
- Bruising,
- Scarring,
- Cuts inside mouth or on lips,
- Slow healing,
- Temporary restriction of mouth opening,
- Increased tooth/teeth mobility,
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate, chin) including loss of taste which may resolve or time, but in some cases may be permanent,
- Nerve injury in the place the graft was taken from or where it is placed,
- Rare chance of disease spread from processed tissue,
- Impact on speech,
- Accidental swallowing of foreign material,
- Failure of the graft,
- Stress or damage to jaw joints (TMJ).

**Risks and Complications of local anesthetic use:** I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Nerve injury, which may occur from the delivery of local anaesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.

**No Warranty or Guarantee:** I understand that the doctor cannot guarantee the results of the procedure. I under-stand that there may be a need for a second procedure if the initial surgery is not satisfactory.

**Consent to Unforeseen Conditions:** During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

**Compliance with Self-Care Instructions:**

In order to increase the chance of achieving optimal results, I have provided and accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand that trauma to the healing areas, smoking, medical conditions, clenching and/or grinding of teeth, dietary and nutritional problems, alcohol intake and medications I may be taking may affect healing and may limit the successful outcome of my surgery.

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good oral hygiene, keep all appointments, make return appointments if complications arise and complete care. I will inform my doctor of my past post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

**Supplemental Records and Their Use:** I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

**Patient's Endorsement:** My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to soft tissue grafting as presented to me during the consultation and treatment plan presentation by the dentist.

_____ _____ _____
Signature of Responsible Party Date Patient's Name

_____
Relationship to Party (if Responsible Party is not Patient)

I confirm with my signature that I have discussed with the above-named patient the risks, potential complications, and intended benefits of the dental implants, as well as alternatives. The patient has had the opportunity to ask questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested that I complete the soft tissue grafting for him/her.

_____ _____
Signature of Dentist Date

_____ _____
Witness to Signatures Only Date