CONSENT TO TREATMENT – GINGIVAL GRAFT

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. Recession of gingival tissue tooth # _____________________________
   b. Missing or lack of attached gingival tooth # ________________________

3. I understand that the following treatments are recommended:
   a. **Gingival Graft** procedure on tooth ________________

   that involves preparation of the soft tissue at the site of the graft, excision of soft tissue on soft palate and suturing the graft at the recipient site.
   i. Prognosis for root covering: **None / Partial / Complete**
   ii. Prognosis augmentation of tissue thickness: **good / guarded**
   b. This procedure can also be conducted under **oral sedation / intra-venous** conscious sedation.
   c. 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:
   a. Follow up every year to assess progression of recession
      i. Prognosis: chance of recession progression **low / medium / high**

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. Post-op: 7,14 days and 2 months after surgery 15 min apt
   c. Follow up: _____________________________

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, ecchymosis
   d. Infection (might require to remove the graft) (rate < 2 %)
   e. Pain
   f. Exposure of the root surface (recession) with dentinal hypersensitivity
   g. Exposure of gaps between the teeth
   h. Exposure of crown and bridge joints
i. Temporary restriction of mouth opening
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 gingival recession
   b. Teeth sensitivity
   c. Compromised esthetic
   d. 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) ___________________________