INFORMED CONSENT FORM FOR GINGIVAL AUGMENTATION SURGERY

1. I, _____, hereby authorize and request Dr. _____ and his assistants to perform gingival augmentation surgery upon me.

2. After a careful examination and study of my dental condition, my dentist has advised me that I have 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, it has been explained to me that it is important to have sufficient width of the attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

3. In order to treat this condition, my dentist has explained to me that there is a gingival augmentation procedure that can be performed in areas of my mouth where I have gum recession. A local anesthetic will be administered to me as part of the treatment. The risks from local anesthesia include numbness, temporary or permanent, infection, altered sensation, discoloration, bruising, swelling, and even in rare circumstances, cardiac death. My dentist has also explained to me that the surgical procedure involves the transplanting of a thin strip of gum from the roof of my mouth and/or from adjacent teeth. This transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed so as to partially cover the tooth root surface exposed by recession. This also can be to augment the attached gum. A periodontal bandage or dressing is then subsequently placed. Stitches may be required.

4. It has been explained to me by my dentist that there are material risks and complications from gingival augmentation surgery. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink during healing. The gum may not attach and may fail. In such cases, the attempt to cover the

exposed root surface may not be completely successful and may fail in its entirety. In other cases, it may result in more recession with increased spacing between the teeth. I also understand that the potential material risks and complications from gingival augmentation surgery include post-surgical infection, bleeding, swelling, pain, facial discoloration, transient or permanent numbness (numbness to the teeth, gums, tongue, lips, chin, cheek and/or jaw), tooth sensitivity to hot, cold, sweet, or acidic foods, and accidentally swallowing foreign material including gum tissue. I also understand that the risks include the failure of the procedure in its entirety, and that subsequent surgery may be necessary to treat any complications that have arisen. These procedures may be necessary to create the desired result or to fix any complications that have been encountered.

5. I acknowledge that there is no method to accurately predict or evaluate how much my gum or bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory in either appearance or functional result. In addition, I understand that the success of gingival augmentation can be affected by my underlying medical or dental conditions, dietary and nutritional problems, smoking, alcohol, clenching or grinding of my teeth, inadequate oral hygiene, inadequate follow up with a dentist or dental hygienist, and the medications that I am taking. I understand that my diligence in performing personal daily care recommended by my dentist and taking all prescribed medications are important to the ultimate health of my gums.

6. My dentist has explained to me the potential alternative treatments to the gingival augmentation surgery. These include, among other things, doing nothing, getting a tooth restored, or further, more extensive periodontal surgery. The risks of these procedures include further gum recession, infection, tooth loss, further damage to the gums and surrounding tissues,

numbness, and harm to my appearance. I reject these alternative treatments and request that Dr. _____ provide me with the gingival augmentation surgery.

The nature of gingival augmentation surgery has been explained to me and I have had a chance to have my questions answered. In light of the above information, I authorize the doctor to proceed with the treatment.

Date:_____ Patient:

_____

Witness:

Guardian:

_____

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