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Consent Form for Gingival (ConnectiveTissue) Graft

An explanation of your need for gingival graft surgery, the procedure care, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo the treatment planned for you. Please read this document which repeats issues we discussed and provide the appropriate signature on the last page. Please ask us to clarify anything that you do not understand and answer any of your questions at any time.

1 – ***EXPLANATION OF DIAGNOSIS*** : I have been informed of the presence of significant gum recession and insufficient gum tissue in my mouth which may be adjacent to muscle attachment. I understand that it is important to have sufficient amount of firm gum tissue around teeth at the gumline to minimize further gum recession which may compromise tooth retention.

2 – ***EXPLANATION OF GINGIVAL GRAFTING(CONNECTIVE TISSUE)*** : I have been informed that the main purpose of gingival (gum) grafting is to create an adequate zone or band (width) of firm gum tissue to help further prevent gum recession. Graft surgery may also be performed to cover exposed roots.

3 – ***RECOMMENDED TREATMENT*** : It has been recommended that gingival grafting be performed in areas of my mouth where I have gum recession. It has been explained that this is a surgical procedure involving the removal of a thin strip of gum tissue from either the surface of my mouth alongside the upper teeth and transplanted (moved) over to the area of the gum recession or exposed root(s). I understand that some or all of the gum placed over the root may shrink back during healing and that proposed surgical attempt to cover the exposed root surface may not be completely successful.

4 – RISKS RELATED TO THE SUGGESTED TREATMENT : Although a low risk procedure, risks related to gingival grafting might include postoperative bleeding, swelling, pain, infection, facial discoloration, temporary or on occasion permanent tooth sensitivity to hot or cold or sweets or acidic foods. A temporary or permanent numbing of the surgical areas may occur on rare occasions. Risks related to the local anesthetics include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of injection of the local anesthetics.

5 – ALTERNATIVES TO SUGGESTED TREATMENT : I have the choice of not receiving any treatment in the area involved. It has been explained to me that doing nothing leaves the tooth open to sensitivity, microbiological insult and eventual **and/or bone and or tooth loss**.

6 – CONSENT TO UNFORESEEN CONDITIONS : During surgery, unforeseen conditions may be discovered which call for a change from anticipated surgical plan. These may include but are not limited to extraction of hopeless teeth to improve healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material or the use of material to guide (enhance) tissue regeneration or termination of the procedure prior to completion of all of the surgery originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating dentist.

7 – NO WARRANTY OR GUARANTEE : I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in treating recessions. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the potential of longer retention of my teeth by reducing the likelihood of further gum recession in the treated area(s) but due to individual patient differences certainty of success is not assured.

Therefore, failure, relapse, selective retreatment, or worsening of my present condition may occur.

8 – **COMPLIANCE WITH SELF-CARE INSTRUCTIONS** : I understand that smoking and/or alcohol intake may adversely affect gum healing or compromised surgical success. I agree to follow instructions related to my own daily care of my mouth. I agree to attend appointments following my surgery as that healing may be monitored and evaluated upon healing completion for future needs.

9 – **USE OF PHOTOS, FILM AND X-RAYS OF ME** : I consent to photography, filming and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my face, my name or other identifying information or characteristics are not revealed or disclosed.

PATIENT CONSENT

I have been fully informed of the nature of the gingival grafting surgery, the procedure to be utilized, the risks and benefits of my treatment, the alternative treatments available and the necessity for pre-, follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with the dentist. After thorough deliberation, I hereby consent to the performance of the sinus augmentation procedure as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgement of the dentist.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

