INFORMED CONSENT FOR GINGIVAL (GUM) GRAFTING

PATIENT'S NAME (PRINTED) _____
Area treated: _____

Expected Benefits The purpose of gingival augmentation is to create an amount of attached gum 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 gum line, or to prevent or treat root sensitivity or root decay.

Gingival Graft – The purpose of **Connective Tissue Graft** is to cover recession and achieve root coverage in order to stabilize gingiva, reduce and prevent teeth sensitivity, cavities and discomfort due to further recession. The purpose of **Free Gingival Graft** is to widen the band of gingiva in order to aid in better oral hygiene, reduce discomfort due to thin gingiva and prevent further recession.

Principle Risks and Complications - Grafts are typically harvested from the palate and I understand that my own gum tissue provides the most predictable result. However, in some cases, Allograft, a graft from other human being, may be used. These options have been discussed. Because each patient's condition is unique, long- term success may not occur in some cases. I understand that complications may result from the surgery, drugs, or local anesthetics. These complications include but are not limited to: pain; swelling; bruising; infection; bleeding; injury to neighboring or adjacent teeth; adverse drug reactions; discomfort; temporary or permanent damage to the nerve which could result in numbness, tingling, burning sensation of the affected area. There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

To my knowledge, I have reported to my doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that I have. I understand that my diligence in providing the personal daily care recommended by my doctor and taking recommended prescribed medications is important to the ultimate success of the procedure.

Necessary Follow-up Care and Self-Care I recognize that natural teeth should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given to me and (2) to comply with recommended periodic examination and preventative treatment.

Costs The estimated cost for this procedure has been provided to me. I understand pre-estimate from the insurance company is only an estimate and I am responsible for any payments that are not paid by the insurance. I agree to be ultimately responsible for payment of the treatment.

I have been fully informed of the surgery to be performed. It was explained to me that the procedure is needed to maintain a healthy periodontal condition. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self care. I realize that during the course of the surgery, the treatment may need to be modified due to existing conditions that are only evident when the surgical site has been exposed. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns. By signing below, I hereby consent to the performance of gum grafting surgery as presented to me and consent to any additional or alternative procedures that may be deemed necessary in the judgment of my doctor.

Patient Signature: _____

Witness Signature: _____

Doctor Signature: _____

Date: _____