SOUTHERN OREGON
PERIODONTICS
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Consent for Gingival Augmentation Surgery

I have been advised that I have significant or potential gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gumline or crowns with edges under the gumline, it is important to have sufficient width of 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.

Gingival Augmentation: I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplanting of a thin strip of gum from the roof of my mouth or from the adjacent teeth or freeze-dried tissue (allograft). The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed to partially cover the tooth root surface exposed by the recession. My tooth may be instrumented and chemically treated prior to the graft placement. A periodontal bandage or dressing may be placed.

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 the teeth and gum line, or to prevent or treat root sensitivity or root decay.

Principal Risks and Complications: I understand that a small number of patients do not respond successfully to gingival augmentation and transplanted tissue procedures. Attempted coverage of exposed root surfaces may not be completely successful, and in some cases, it may result in more recession with increased spacing between the teeth.

I understand that complications may result from gingival augmentation or from anesthetics. These complications include, but are not limited to: post-surgical infection, bleeding, swelling, and pain, facial discoloration, transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

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 initial surgery is not satisfactory. In addition, the success of gingival augmentation 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 the Periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by the Periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment: Alternative treatments for my gum recession include: no treatment, continued monitoring for progressive recession, and modification of technique for brushing my teeth.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of gingival augmentation.

I recognize that natural teeth and appliances 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 the Periodontist 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:

- to abide by the specific prescriptions and instructions given by the Periodontist and
- to see the Periodontist for periodic examination and preventive treatment.

Maintenance may also include adjustment of prosthetic appliances.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, the Periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records: I authorize photographs and radiographs of my care and treatment during or after its completion to be used for the advancement of dentistry and or reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

I certify that I have read, understood, and consent to the terms put forth in this document:

Print name: _____ Signature_____ Date_____