

Gum Surgery Consent Form

Dr. Jason Hwang

I, _____, hereby authorize Dr. _____ to perform the following surgical procedure(s) as indicated below.

A. Crown Lengthening Surgery

B. Mucogingival Surgery – Gingival Graft Surgery

C. Regenerative Surgery – Osseous grafts and/or Guided Tissue Regeneration

D. Replaced Flap Surgery

E. Other: _____

I understand that I have a form of periodontal disease or a periodontal condition that has caused damage to the soft tissues and/or bone around my teeth. This disease or condition, if left untreated, is generally non-reversible and can be progressive, eventually leading to further damage and possible loss of my teeth.

I also understand that a variety of surgical procedures are used to treat periodontal disease. While these surgical treatments are generally successful, I understand that no guarantee, warranty, or assurance has been given me that the proposed surgical treatment will be curative and/or successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present condition may result despite the treatment.

It has been explained to me that long term success of treatment requires my cooperation and performance of effective plaque control (home care) on a daily basis and periodic periodontal maintenance visits at a dental office after the proposed surgical treatment performed.

I further understand that if no treatment is rendered, my present periodontal condition has the potential to worsen with time and may result in premature tooth loss.

I have been informed that other possible alternative methods of treatment include scaling and root planning followed by periodic maintenance.

Although significant complications from periodontal surgery are rare, they can occur and may include the following: A. Intra-surgical: bleeding, perforation of sinus membranes, nerve damage B. Post-Surgical: bleeding, swelling, infection, discomfort, tooth sensitivity, tooth looseness, gum recession (shrinkage), numbness or altered sensation, exposure of crown margins.

I certify that I have fully read and understand the above consent to the surgical treatment, the explanation therein referred to or made before I signed this document.

Patient signature: _____ Date: _____