

## INFORMED CONSENT FOR PERIODONTAL OSSEOUS SURGERY

**Diagnosis:** After a careful oral examination, radiographic evaluation and study of my dental condition, the dentist has advised me that I have bone loss and/or gum pockets around my teeth from periodontal disease. Various forms of periodontal diseases are fairly common. I understand that periodontal disease weakens the support of my teeth by separating the gum from my teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further loss or erosion of bone and gum tissue supporting the roots of my teeth. If left untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences, which may include systemic problems such as cardiovascular disease, heart attack and stroke. Advanced periodontal disease is the primary reason adults lose teeth.

**Recommended Treatment:** The dentist has advised me that I would benefit from periodontal osseous surgery (pocket reduction surgery). I understand that oral sedation may be utilized and that local anesthetic (commonly called Novocain) will be administered as part of the surgery. I further understand that antibiotics and other substances may be applied to the roots of my teeth during surgery. The gum will be trimmed and pulled away from the teeth to permit better access to the roots and jawbone. The infected and inflamed gum tissue will be removed and the root surface will be thoroughly cleaned. Bone irregularities may be reshaped. The gum will then be sutured back closer to the new bone level and a periodontal bandage or dressing (periopack, plaster dressings) may be placed. The surgery will make it look like the gum has receded, making the teeth look longer and resulting in spaces between them as the gum papilla (pointy part of the gum between the teeth) is lowered.

**Expected Benefits:** The purpose of periodontal osseous surgery is to reduce infection, inflammation and flatten bone deformities created by periodontal disease to reduce the gum pockets. This surgery is intended to help me significantly improve the chances of keeping my teeth in the operated area and to make my oral hygiene more effective. It should also enable professionals (Dentist, Hygienist) to better clean my teeth. It is also intended to remove bacteria, which is a potential complication for my overall health.

**Principal Risks and Complications:** I understand that a small number of patients do not respond successfully to periodontal surgery. Unforeseen conditions may call for modification or change from the anticipated surgery plan. These may include, but are not limited to, a recommendation to extract some or all teeth, or to terminate the procedure prior to completion as originally planned.

Other things in the future such as: accidents, root canal problems, tooth decay, periodontal disease, etc. could also cause the loss of teeth we are trying to treat with periodontal osseous surgery.

Complications may result from the periodontal osseous surgery, involving the gums or jawbone, or from drugs and anesthetics. These complications include but are not limited to post-surgical infection, bleeding, swelling, pain, bruising; numbness of the jaw, lip, tongue, chin or gum; jaw joint pain or muscle spasm; cracking or bruising of the corners of the mouth; restricted ability to open the mouth for several days or weeks; impact on speech; allergic reactions; accidental swallowing of foreign matter; transient (on rare occasion permanent) increased tooth looseness; tooth sensitivity to hot, cold, sweet or acidic foods; staining of the teeth, restoration and tongue

(use of Peridex rinse); shrinkage of the gum upon healing, resulting in elongation of some teeth and greater spaces between some teeth; injury to adjacent tissue, teeth, caps, fillings or other dental work; need for possible future orthodontic treatment and/or additional surgeries. Please be aware because each patient's condition is unique, long term success may not occur.

Generally speaking, the earlier periodontal pocketing and bone defects are surgically corrected, the better and more predictable the surgical outcome. Advanced cases are the opposite. That is not to say surgically treating advanced cases may not be beneficial, but textbook results are usually obtainable only in early treated cases.

All things being equal, smokers are 3 times more likely to lose teeth from periodontal disease, and diabetics have more periodontal disease than non-diabetic. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, 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 dentist and/or his/her staff any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that I may have.

There is no method that will accurately predict or evaluate how my gum and bone will heal after the surgery is done. I understand that there may be a need for a second surgery if the initial results are not satisfactory, or if the disease returns in the future.

**Alternatives to Suggested Treatment:** Alternatives to periodontal osseous surgery include:

1. No treatment with the expectation of possible advancement of my disease, which may result in premature loss of teeth. Studies show people with untreated periodontal disease are about 6 times more likely to lose teeth than ones that have successful periodontal pocket reduction surgery, and are 3 times as likely to suffer from a heart attack or stroke.
2. Non-surgical scraping of tooth roots and lining of the gum (root planning and scaling), with or without medication, in an attempt to further reduce bacteria and tartar under the gum line with the expectation that this will not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care, time and commitment, and may result in the worsening of my condition and the premature loss of teeth. Furthermore, studies show people with untreated periodontal disease seen for regular cleanings only are about 3 times more likely to lose teeth than one's that have successful periodontal pocket reduction surgery and stay on regular tooth cleaning schedule.
3. Extraction of teeth involved with periodontal disease.

**Necessary Follow-Up Care and Self-Care:** I understand that it is important for me continue to see my regular dentist for routine dental care. Regular, thorough dental cleanings are essential from here on out. Furthermore existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, the dentist may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the extraction of one or more teeth, the performance of root canal therapy, or the orthodontic movement of one, several or all of my teeth. I understand that failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

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 dentist 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:

1. Abide by the specific prescription and instructions given
2. See the dentist for post-operative check-ups as needed
3. Quit smoking
4. Perform excellent oral hygiene as instructed, usually starting 1 week post-op
5. Stay on regular hygiene maintenance schedule

I have told the dentist and/or his/her staff about any pertinent medical conditions I have, allergies (especially to medications or sulfites) or medications I am taking, including over the counter medications such as aspirin.

**No Warranty or Guarantee:** I acknowledge 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 keep my teeth. Due to individual patient differences, however, there can never be a 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 photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

**Communication with my Insurance Company, My Dentist or other Dental/Medical Providers Involved with My Care:** I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, the doctors billing agency, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

**Females Only:** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle (besides just birth control pills) after a course of antibiotics is completed.

**Administration of Local Anesthetic:** Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol, or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of the same.

**Procedure(s) to be performed:**

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I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the dentist. I have read and understood this document before I signed it.

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Signature of Patient, Parent or Guardian

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Printed Name

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Date

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Signature of Dentist

\_\_\_\_\_  
Printed Name

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Date