Consent for Gingival Augmentation Surgery

Patient Name: **Date:**

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.

_____1. My condition has been explained to me by Dr. Schetritt as:
Lack of attached tissue in the area of _____.

_____2. The procedure necessary to treat my condition is "gingival augmentation surgery" utilizing AlloDerm" (tissue donated by cadaver). The purpose of gingival augmentation is to create an amount of attached gum tissue around my teeth or implants. This procedure involves the transplanting of a thin strip of gum tissue from the palate of my mouth or from adjacent teeth. This tissue can be placed at the base of the remaining gum or it can be placed so as to partially cover the tooth root surface exposed by recession and areas deficient of tissue around dental implants. A periodontal packing or bandage may be placed in the area to keep it protected during the healing phase.

_____3. I have been informed of possible alternate methods of treatment (if any) including no treatment. I understand that these other forms of treatment or no treatment at all are choices I have and the risks of those choices have been presented to me.

_____4. My doctor has explained to me that there are certain risks and side effects associated with my proposed treatment and, in this specific instance, they include, but are not limited to:

_____A. Post-operative discomfort and swelling requiring several days of at-home recovery.

_____B. Prolonged or heavy bleeding that may require additional treatment.

_____C. Injury or damage to the blood supply of teeth adjacent to the graft donor site.

_____D. Post-operative infection that may adversely affect the new graft and require additional treatment.

_____E. Scarring at the site of incisions inside the mouth, which may also have cosmetic effects on the skin.

_____F. Injury to sensory nerves in either donor or recipient sites, resulting in numbness, tingling, pain, or loss of taste and other sensory disturbances in the chin, lip, cheek, face, teeth, gums or tongue, which may persist for several weeks or months, or rarely may be permanent.

_____ N. Allergic reactions (previously unknown) to any medications and/or materials used in treatment.

_____5. There is no method that will accurately predict or evaluate how my gum 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.

_____6. I understand that no guarantee, warranty or assurance 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 and/or dental implants. Due to individual patient differences Dr. Schetritt cannot predict certainty or success.

I certify hat I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to.

I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any were stricken out before I signed. I also state that I speak, read, write and understand English.

Patient or Legal Guardian Signature **Date**

Witness Signature **Date**

Doctor's Signature **Date**