

**FREE GINGIVAL GRAFT
CONNECTIVE TISSUE GRAFT**

AUTHORIZATION AND CONSENT TO PERIODONTAL SURGERY

Patient: _____ DOB: _____

1. It has been explained to me that I have periodontal (gum) disease or other gum problems and that I require the following procedure(s) : the use of local anesthetic (freezing), moving gum tissue from one portion of my mouth and grafting it to another, use of sutures, use of a dressing or covering of the site.
2. I understand that risks of the recommended treatment include, but are not necessarily limited to: (a) allergic or other reactions to the local anesthetic or other medications used, (b) swelling and/or infection, (c) pain and/or thermal sensitivity, (d) exposure of root surfaces (gum recession) and/or margins of crowns (caps), (e) increased tooth mobility, (f) temporary restricted mouth opening, (g) numbness of jaw or gum nerves.
3. I understand if no treatment is rendered the risks to my dental health include,, but are not limited to: (a) further deepening of periodontal l(gum) pockets, (b) halitosis (bad breath), (c) gum abscesses (boils), (d) loosening or drifting (movement) of teeth, (e) uncontrolled gum recession, (f) premature loss of teeth.
4. No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth. However, it is Doctor’s opinion that therapy will be helpful, and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.
5. It has also been explained to me that in order for me to achieve long term benefits from my treatment it is required that I perform effective daily oral hygiene (plaque control procedures) and regularly attend for “cleanings” (maintenance care).
6. I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SATISFACTORILY SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT BEFORE HEREBY SIGNING.

DATE: _____ SIGNED _____
Patient or Legal Guardian

Witness