DENTAL SPECIALTY CENTER
FALCON

INFORMED CONSENT FOR SURGICAL TREATMENT OF GINGIVAL RECESSION

Patient's name (printed): _____ **Date of birth:** _____

DIAGNOSIS: Following a thorough review of my medical & dental history, as well as comprehensive periodontal examination of my clinical & radiographic conditions, I have been diagnosed with **gingival recession** in the following areas of my mouth:

_____

Gingival recession occurs when the gum tissues surrounding a tooth migrate to expose the tooth's root surface. Because the exposed root is not covered by a protective layer of enamel, it is susceptible to sensitivity and decay.

Although the *presence of plaque or calculus* can contribute to gingival inflammation and tissue loss, gingival recession often occurs in areas of the mouth where the patient maintains excellent oral hygiene. In some cases the causes are related to a history of incorrect or *excessively vigorous brushing. Poor tooth alignment* can also contribute to the problem, as can *heredity,* where nature leaves a patient with naturally thin and fragile gingival tissues.

When gingival recession occurs in the back of the mouth, the process may go unnoticed until the patient begins to experience sensitivity. Unfortunately, in some cases the patient notices no sensitivity until root decay has progressed to the point that the tooth is no longer restorable. On the other hand, when gingival recession takes place in the esthetic zone, patients are often alerted to the problem earlier in the disease process, when they first notice the appearance of unsightly exposed roots.

TREATMENT OPTIONS: Left untreated, gingival recession will usually progress - producing *tooth sensitivity, loss of esthetics* and an *increased risk of root decay* and *tooth loss*. Although there is no way to correct the problem without surgery, progression can be minimized with *modification of tooth brushing & flossing techniques, regular hygiene appointments* and careful *professional monitoring.* The risks and benefits of the following surgical treatment options have been explained to me in detail, and my questions have been answered satisfactorily.

- ❑ **free gingival graft** – tissue is taken from a donor site (*usually on the roof of the mouth*) or donor bank and is sutured into place over the area of gingival recession; generally, quite effective, although color match may not be ideal; recovery time of about 2 weeks; increased post-operative discomfort due to 2 surgical sites.
- ❑ **connective tissue graft** – incisions are made adjacent to the gingival recession area to create a flap. Underlying tissue taken from a donor site (*usually on the roof of the mouth*) or donor bank is positioned over the recession area; then the flap tissue is laid down over the grafted tissue and sutured to place. Good color matching; recovery time of about 2 weeks, increased post-operative discomfort due to 2 surgical sites.
- ❑ **pedicle graft** – instead of taking tissue from a donor site, gum tissue is grafted from an area adjacent to the tooth or teeth needing a graft. The flap, called a *pedicle*, is positioned over the exposed root and sewn into place. Excellent color matching results, but this procedure works only if the patient has adequate available gum tissue in the area.
- ❑ **no treatment** – gingival recession will progress **-** producing *tooth sensitivity, loss of esthetics* and an *increased risk of root decay* & *tooth loss.*

PLANNED TREATMENT: Based upon my clinical conditions, and after discussion with me of the types of treatment best able to address my specific needs, my doctor has recommended the following treatment:

_____

MEDICATIONS: I understand that I may be prescribed pain medications or antibiotics as a result of this surgical procedure. I agree to take all prescribed medications as directed. Should I experience any signs of allergic reaction (*rash, itching, difficulty breathing*), I agree to stop taking those medications and contact my treating doctor or 911 immediately. I understand that prescribed medications may cause drowsiness and lack of coordination (*which may be intensified with the use of alcohol, tranquilizers, sedatives, or other drugs).* I know I should not operate any vehicle or hazardous device while taking pain medications.

RISKS AND COMPLICATIONS: I understand that all of the treatment options listed require the use of local anesthesia. Rarely, post-operative complications from local anesthesia can occur and include *temporary* or even *permanent numbness of the lips, chin* and *gums.* I have informed the doctor of any past complications with local anesthesia.

In some cases, unforeseen circumstances may call for changes to the anticipated surgical plan. These may include, but are not limited to: *treatment of fewer teeth or inclusion of additional teeth than originally planned or termination of the procedure if the doctor finds it in the patient's best interest.* In some cases*, treatable dental decay* located beneath the gumline may be discovered which must be removed and restored prior to completing the surgery. In rare cases, root decay may be so extensive that restoration of the tooth is not possible and the only option is extraction. I understand that treatment changes could result in additional fees being charged.

I understand that the amount of root coverage achieved through surgery will depend upon many factors including, but not limited to: *the severity of recession, blood supply to the tissues, amount of tissue* and *bone loss between the teeth*, the patient's overall *oral and general health a*nd compliance with *post-operative instructions*. I have been informed that smoking and alcohol can significantly affect the amount of root coverage achieved and healing times. I understand that a second procedure may be required if the initial surgery results are not satisfactory. Complications of any of the surgical treatment options may include, but are not limited to: *bleeding, bruising, pain, infection, transient or even permanent tooth sensitivity, soreness from holding my mouth open, allergic reactions* and *accidental swallowing of foreign matter*.

INFORMED CONSENT:

_____ The estimated fees for this procedure have been explained to me and I accept them as satisfactory. I agree to be responsible for payment of the treatment.

_____ I have informed the doctor and his staff of any changes to my medical history, including all *medications, allergies, past hospitalizations, tobacco & alcohol use.* I have informed the doctor if I am *pregnant* or *breast feeding.* I agree to follow any and all post-treatment instructions and will permit recommended diagnostic procedures, including x-rays. I understand that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure.

_____ I have been fully informed of the surgery to be performed. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up appointments and adherence to post-operative instructions.

_____ I understand that I may be prescribed pain medications or antibiotics as a result of this surgical procedure. I agree to take all prescribed medications as directed. Should I experience any signs of allergic reaction (*rash, itching, difficulty breathing*), I agree to stop taking those medications and contact my treating doctor or 911 immediately. I understand that prescribed medications may cause drowsiness and lack of coordination (*which may be intensified with the use of alcohol, tranquilizers, sedatives, or other drugs).* I know I should not operate any vehicle or hazardous device while taking pain medications.

I can read and write English and have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, which may be associated with any phase of this treatment in hopes of obtaining the desired result. If I am sedated during the procedure, I authorize the doctor to modify the procedure, if, in his/her professional judgment, it is in my best interest.

I understand that it is my responsibility to notify the doctors and/or staff of _____ if I experience any difficulties as a result of treatment, so that they can act on my behalf to try to resolve the problem. If their attempts to correct the issue are unsuccessful, I understand that I may be referred to another health care practitioner for care.

Signed: _____ Date: _____
Patient or Legal Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness

TO BE ADDED TO THE FORMS FOR GENERAL DENTISTS:

I understand this treatment can also be performed by a periodontist (*gum surgery specialist*). I understand the risks and elect to have this procedure performed by Dr. _____.