DENTAL SPECIALTY CENTER
FALCON

INFORMED CONSENT FOR PERIODONTAL PLASTIC SURGERY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

DIAGNOSIS & BENEFITS OF PLANNED TREATMENT. Gingivoplasty involves sculpting and contouring of healthy gingival *(gum)* tissues to achieve improved esthetics. In some cases, this treatment is used to address areas of highly pigmented gum tissue that a patient may find objectionable. **Gingivoplasty** is usually restricted to the eruisthetic zone of the mouth. This surgery has been recommended for me because of a diagnosis of *reduced smile dynamics* due to:

- ❑ excessive display of gum tissue
- ❑ inadequate exposure teeth in the esthetic zone
- ❑ irregular/asymmetrical gingival margins
- ❑ gingival hyperpigmentation
- ❑ medically-induced gingival hyperplasia/enlargement

After careful examination and study of my medical and dental conditions, and discussion with me regarding my functional and esthetic desires, my doctor has advised me that I would benefit from **gingivoplasty** procedure in the following area(s):
TREATMENT AREA(S): _____

TREATMENT OPTIONS: I understand that **gingivoplasty** involves esthetic surgical treatment of healthy gum tissues. The following treatments represent available treatment options for gingivoplasty. Prior to the procedure I have been informed that my teeth will be thoroughly cleaned to remove any residual plaque. Treatment will take place under local anesthesia. Following treatment, my periodontist may place a dressing over the gum tissue to aid in healing. Reshaping of my gingival tissue can be accomplished in the following ways:

- **Laser.** A laser can be used to efficiently reshape gum tissues. Because this method cauterizes the tissues, sutures are generally not required; this method works well for patients taking blood thinners.
- **Scalpel.** This method is very precise with minimal damage to adjacent tissues and comparatively faster wound healing than electrosurgery.
- **Electrosurgery.** This method appears to offer relatively quick wound healing, with minimal bleeding. However, because tissue is burned, patients may find the odor objectionable. Electrosurgery cannot be used on patients with older pacemakers that are not shielded against external interference.

RISKS AND COMPLICATIONS: In general, **gingivoplasty** is performed under **local anesthetic.** Depending upon the amount and type of tissue that requires removal and/or recontouring, surgery may involve placement of sutures and/or a periodontal dressing.

Although gingivoplasty is a minor surgical procedure, it is not without risks, which could be the result of the treatment itself or from anesthetics or drugs administered. These complications include, but are not limited, to *post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days/weeks, impact on speech, allergic reaction (potentially life-threatening), anesthetic overdose, accidental swallowing of foreign matter, tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods & transient (on rare occasions, permanent) numbness of the jaw, lip, tongue, chin or gums. Complications may be irreversible or of an unknown duration.* **Females***: Use an additional form of birth control (other than birth control pills) for one complete cycle, if prescribed antibiotics.*

There is no method to accurately predict, prior to treatment, how my gums will respond to surgery. I understand that there may be a need for a second surgery if initial results are unsatisfactory. I am aware that poor oral hygiene & certain medications promote gingival overgrowth and that re-treatment, at additional fees, may be required to maintain

treatment results. In some cases, my doctor may have to change, modify, or terminate the original surgical plan based on my clinical conditions. Following removal of gum tissue, I understand that my doctor could discover deep decay, fractures or other pathology needing treatment that was previously hidden from view. I am aware that tissue shrinkage following treatment may expose sensitive root surfaces of my teeth.

TREATMENT ALTERNATIVES: Alternatives to **gingivoplasty** include:

1) **No treatment.** I understand that gingivoplasty is an elective esthetic procedure. I am under no obligation to pursue this treatment.

FOLLOW-UP/SELF-CARE: I understand that it is my responsibility to return for recommended post-operative checkups. Should I experience post-operative complications such as excessive *bleeding or swelling, fever* or *malaise,* I will contact this office right away. I have informed my doctor of all pertinent medical conditions, allergies, and any over-the-counter medications that I'm taking. I have been informed that smoking, poor oral hygiene and excessive alcohol use have a very negative effect on wound healing.

NO WARRANTY OR GUARANTEE: Although gingivoplasty is usually successful, no guarantee, warranty or assurance has been given to me in regard to the outcome of the proposed surgical procedure. Despite the very best of care, individual differences make it impossible to ensure that every surgery is successful.

INFORMED CONSENT: 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 (***gingivoplasty)*** and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. I understand medically-induced gingival hyperplasia/enlargement may still occur due to medications I am taking and I must discuss with my physician the option of changing medications. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. I have been informed of my diagnosis, the planned procedure(s), the risks, benefits and alternative treatments associated with this procedure. If I elect to have any additional forms of anesthesia other than local anesthetic, I agree to review and sign **separate informed consents.**

By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

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CONFIRMATION OF MEDICAL HISTORY:

YES	NO	History of taking bisphosphonates for ***metastatic bone cancer;*** Treatment year: _____
YES	NO	History of taking bisphosphonates for ***osteoporosis:*** (*i.e. Boniva, Fosamax, Actonel, Reclast*, etc.)
YES	NO	Radiation treatment to the head or neck area
YES	NO	Bleeding problems;
YES	NO	Wear a pacemaker; Year pacemaker was placed: _____
YES	NO	Taking blood thinner medications; Taking daily aspirin;
YES	NO	Taking anticoagulants (i.e. *Coumadin, Plavix, Lovenox, Fragmin, Angiomax*)
YES	NO	Predisposed to food allergies, asthma or hives
YES	NO	Pregnant, recent pregnancy or nursing
YES	NO	History of taking *phenytoin, PHT, mephenytoin, valproate, phenobarbitone, vigabatrin, primidone*
YES	NO	History of taking *cyclosporin, sirolimus, tacrolimus, ethosuximide*

Patient name *(printed):* _____

Patient/guardian name *(signature):* _____ **Date:** _____

Relationship to patient: ❑**Self;** _____

Signature of Dentist: _____ **Date:** _____