DENTAL SPECIALTY CENTER
FALCON

INFORMED CONSENT: OSSEOUS SURGERY

Including *Guided Bone Regeneration & Guided Tissue Regeneration*

Patient name (printed): __________________________ **Date of Birth:** _________________________________

DIAGNOSIS: ***Periodontitis*** is an inflammatory disease affecting both the gums and underlying bone. Over time, the diseased gums begin to pull away from the teeth and form periodontal pockets. Left untreated, this bacterial infection can destroy the supporting bone, resulting in *pain, infection, bleeding gums, loose teeth, bad breath,* and eventually*, tooth loss.*

After a comprehensive dental examination with review of my periodontal and radiographic findings, Dr. ________________________ has recommended treatment of my condition (**diagnosis documented below**) with **periodontal osseous surgery.**

- ❑ ADA Stage 2, Grades A, B periodontitis Area(s): ____
- ❑ ADA Stage 2, Grade C periodontitis Area(s): ____
- ❑ ADA Stage 3, Grades A periodontitis Area(s): ____
- ❑ ADA Stage 3, Grades B, C periodontitis Area(s): ____

RECOMMENDED TREATMENT.

- ❑ **Osseous gum surgery -** My doctor has recommended **osseous gum surgery** *(gingival flap surgery)* because it is an effective way of treating more *advanced gum disease* in patients in which the underlying *bone* requires *re-contouring.* During this surgery, the gum tissue is gently lifted from the affected tooth (*teeth*) and bone to *allow the doctor to clearly see and access diseased tissues.* After bony defects are re-contoured and diseased gum tissue is removed, *antibiotics &* other *medications, as well as bone regenerative materials* & *membranes* may be applied to the roots of my teeth to help encourage & direct the development of new supporting bone. S*titches* are placed to secure the tissues during healing. This surgery will make it easier to remove plaque from areas of the teeth which were previously inaccessible & will help prevent future infection. I understand that local anesthetic will be administered as part of the treatment and that sedation may be utilized.

EXPECTED BENEFITS. The purpose of periodontal surgery is to *reduce infection and inflammation* and to restore my gums and bone to the extent possible. The surgery is intended to remove diseased tissue to *help me keep my teeth* in the operated areas and to help make oral hygiene efforts more effective for me and also for dental health professionals treating my condition.

ALTERNATIVES TO SUGGESTED TREATMENT.

- ❑ **Laser assisted new attachment procedure (LANAP®) –** Instead of incisions, a fiber-optic tip is placed inside the pocket and run parallel to a tooth root or implant, as it selectively removes toxins and diseased tissue. This procedure promotes reattachment of remaining healthy tissue to the tooth & stimulates bone growth. Compared to traditional osseous surgery, laser surgery offers a *shorter healing & recovery time, no incisions or sutures (stitches) & reduced post-operative pain.* This option is less desirable when the doctor needs to fully visualize the diseased underlying tissues to effectively remove toxins and recontour bony defects.

- ❑ **Scaling and root planing (SRP) -** non-surgical removal of bacteria and toxins from the tooth and root surfaces, which may be accomplished with or without medication, but does not involve bone recontouring. Because of limited access, deep bacteria and calculus (*tartar*) may not be fully eliminated.

- ❑ **No treatment.** Without treatment, bad breath, infection & progressive loosening of teeth will occur. A chronic low-grade infection like periodontitis can have negative effects on overall health and has been associated with *heart disease, diabetes* & *low birth weight babies.* Studies have shown that people with untreated periodontal disease are about 6 times more likely to lose teeth than those successfully treated with osseous surgery in which periodontal pockets are reduced.

- ❑ **Tooth extraction**

RISKS AND COMPLICATIONS OF RECOMMENDED TREATMENT (osseous gum surgery): Unforeseen conditions may require that the anticipated surgery plan be modified. These may include, but are not limited to, a recommendation to *extract some teeth* or *terminate the procedure* prior to completion.

- **SMOKING/ALCOHOL USE**. I understand that smoking and/or non-moderate use of alcohol can negatively affect treatment results and that treatment outcomes will be significantly improved if I permanently stop smoking and reduce alcohol consumption. I agree not to smoke or drink alcohol in the first 48 hours following osseous surgery.
- **POOR RESPONSE TO TREATMENT**. There is no way to reliably predict how each person will react to treatment due to variations in human physiology, severity of periodontal disease, oral hygiene levels and compliance with treatment recommendations. In some cases, osseous surgery will not produce the desired results. Teeth may become temporarily loose *(in rare cases – permanently).* I understand that after an appropriate healing period, I will be re-evaluated to determine my response to treatment. I have been informed that, should the desired results not be attained, additional treatment (*including retreatment, surgery or tooth extraction),* including referral to another doctor, may be required.
- **COSEMTIC CHANGES:** After healing occurs, and infected & swollen gum tissues are treated, some tooth roots or restoration margins (*edges of crowns or fillings*) may be exposed & require additional treatment. Spaces between teeth may appear more prominent & in some cases, the teeth may seem longer.
- **LOCAL ANESTHETIC COMPLICATIONS**: There are inherent risks and side effects of local anesthetic used for pain control during dental procedures. They include, but are not limited to: *swelling, facial bruising, soreness, elevated blood pressure or pulse, allergic reaction, interaction with drugs* I am taking and *altered sensation* that may lead to *self-injury.* Partial or complete numbness may linger after the dental appointment & in rare cases, can last for an extended time & potentially it can be permanent. I have fully informed my doctor of any local anesthetic complications I have experienced in the past.
- **PAIN, SORENESS & SENSITIVITY:** Following osseous flap surgery, some bleeding & soreness may occur. It is not unusual for patients to experience post-operative discomfort which may be transitory or permanent, may be related to hot & cold stimuli, contact with teeth, and sweet and sour foods. Further treatment may be required. Sensitivity may persist, despite treatment.
- **FAILURE OF PATIENT TO TAKE RESPONSIBILITY FOR CARE**: I understand that I will play a critical role in the success or failure of periodontal treatment. I understand that it is vital that I follow all hygiene, dietary and post-operative instructions given. I recognize that keeping my teeth clean and plaque-free is necessary to prevent disease progression. I understand that regular periodontal maintenance (*generally, every 3 months)*, or as directed by my doctor or hygienist, is required to monitor and prevent worsening of my periodontal condition.
- **OCCLUSAL ADJUSTMENT** *(bite modification)* **& EQUILIBRATION** *(balancing of the bite):* I understand that following osseous surgery, some of my teeth may shift position. In some cases, changes to my bite may be significant. I understand that my doctor may perform an ***occlusal adjustment*** and/or ***equilibration*** to eliminate traumatic biting forces which could compromise treatment success. In some cases, adjustment procedures may require the removal of porcelain, metal or tooth structure and could require the fabrication or replacement of fillings, crowns, or bridges. I understand that missing teeth should be replaced to prevent the exertion of excessive biting forces on my remaining teeth.

MEDICAL HISTORY: I have informed the doctor of any & all of my *medical conditions, medications* and *allergies.* I have informed the doctor if I am *pregnant*, *breast-feeding or have a history of bisphosphonate or blood thinner use.*

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 Taking blood thinner medications or 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*

INFORMED CONSENT: I can read and write English. I have been given adequate time & opportunity to ask any questions regarding my diagnosis and the nature and purpose of the proposed treatment. I 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. The fees for these services have been explained to me & I accept them as satisfactory.

By signing this form, I am freely giving my consent to authorize the doctors and staff at this practice to render any services they deem necessary or advisable to treat my dental conditions, including the administration and/or prescribing of any *anesthetic, analgesic & sedative agents* and/or *medications.* I have informed my doctor of any & all my medical conditions, medications, allergies & hospitalizations. I agree to follow all written and & post-operative instructions and to take medications as prescribed. I agree to arrange for someone to transport me from the dental office should the doctor and/or staff recommend it. I understand that in some cases, the dentist may take photos of my mouth during treatment to be used for professional educational purposes.

The doctors and/or staff at this office have made no guarantees of a successful outcome. I understand that if I experience any problems that it is my responsibility to notify the doctors and/or staff 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. I acknowledge that I have read this document in its entirety, that all blank spaces have been either completed or crossed off prior to my signing.

______________________________ ____________ Patient date of birth: ______________________
Patient/Guardian Signature Date

______________________________ ____________
Doctor Signature Date