CONSENT FOR PERIODONTAL SURGERY

DIAGNOSIS. After a careful oral examination and study of my dental condition, Dr. Yaholnitsky has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth and possibly destroyed some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result further erosion or loss of bone and gum supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health.

RECOMMENDED TREATMENT. In order to treat this condition, Dr.Yaholnitsky has recommended that my treatment include periodontal surgery. I understand that oral sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

During this procedure, my gum will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped, and bone regenerative material may be placed around my teeth. My gum will then be sutured back into position, and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, (1) extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

EXPECTED BENEFITS. The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help my keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

PRINCIPALS RISKS AND COMPLICATIONS. I understand that a small number of patients do not respond successfully to periodontal surgery, and in such cases, the involved teeth may eventually be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur.

Initials_____

I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment or prosthetic appliances.

NO WARRANTY OR GUARANTEE. I hereby acknowledge that no guarantee, warranty or assurance has been given to me 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. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

PUBLICATION OF RECORDS. I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without permission.

Patient Consent

I have been informed of the nature of this periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had and opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Yaholnitsky and his staff members. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Yaholnitsky.

Date [Printed name of patient, parent or guardian]

[Signature of patient, parent or guardian]

Date [Printed name of witness]

[Signature of witness]