CONSENT FOR GINGIVAL AUGMENTATION SURGERY

DIAGNOSIS: After a careful oral examination and study of my dental condition, Dr. Yaholnitsky has advised me that I have significant gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gumline or crowns with edges under the gumline, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

RECOMMENDED TREATMENT: In order to treat this condition, Dr. Yaholnitsky has recommended that gingival augmentation (gum grafting) procedures be performed in areas of my mouth with significant gum recession or soft tissue collapse.

SURGICAL PHASE: I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplanting of a thin strip of gum from elsewhere in my mouth or an inert piece of donor tissue harvested and sold as a product called Alloderm®. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed so as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

EXPECTED BENEFITS: The purpose of gingival augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Other purposes for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, to prevent or treat root sensitivity or root decay and to build up gum collapse in the dental ridge.

PRINCIPAL RISKS AND COMPLICATIONS: I understand that a small number of patients do not respond successfully to gingival augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed in some cases, it may result in more recession or with increased spacing between the teeth.

If a transplant is placed to fill out gum collapse, the gum placed may shrink back during healing and result in a residual area of collapse. This may require further procedures to eliminate.

I understand that complications may result from gingival augmentation or from anesthetics. These complications include, but are not limited to (1) post-surgical infection, (2) bleeding, swelling, and pain, (3) facial discoloration, (4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, (5) allergic reactions, and (6) accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

Initials

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There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of gingival augmentation can be affected by (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) alcohol consumption, (5) clenching and grinding of my teeth, (6) inadequate oral hygiene, and (7) medications that I may be taking. To my knowledge I have reported to Dr. Yaholnitsky any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure.

I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

ALTERNATIVES TO SUGGESTED TREATMENT: Dr. Yaholnitsky has explained alternative treatments for my gum recession or collapsed gum tissue. These include no treatment, continued monitoring for progressive recession, and increasing length of an artificial tooth to fill the area of collapse.

NECESSARY FOLLOW-UP CARE AND SELF-CARE: It is important for me to continue to see my regular dentist for routine dental care and to get the missing tooth/teeth replaced as recommended.

I understand smoking and smokeless tobacco may adversely affect healing and may cause pain and/or a poor result, especially if used during the 1 st month.

I have told Dr. Yaholnitsky about any pertinent medical conditions I have, known allergies (especially to medications), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Yaholnitsky about any present or prior head and neck radiation therapy.

I have told Dr. Yaholnitsky about any present or prior use ofbisphosphonate medications. Some common brand names are Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®.

I need to come back in for several post-operative check-ups so that healing may be monitored and so Dr. Yaholnitsky can evaluate and report on the outcome of surgery to my dentist. It may be necessary to remove both non-resorbable sutures and non-resorbable membranes used in the bone regeneration surgery.

Initials _____

I know that it is important to:
1. Abide by the specific prescriptions and instructions given.
2. See Dr Yaholnitsky for post-operative check-ups as needed.
3. No smoking or use of smokeless tobacco for 1 month as noted above.
4. Have any non-dissolvable sutures (stitches) and membranes removed.
5. Get the tooth/teeth replaced as recommended.

NO WARRANTY OR GUARANTEE: While in most cases the surgical area heals quickly and with out any problems, complications such as those listed previously, can happen despite the best of care.

PUBLICATIONS OF RECORDS: ▮ authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry, in written or internet publications or sites, and in promotional materials. My identity will not be revealed to the general public.

PATIENT CONSENT:
I have been informed of the nature of this gum grafting surgery, the procedure to be utilized, the risks and benefits of the 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]