INFORMED CONSENT FOR
EXPOSE AND BOND

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DDS | MS

DIAGNOSIS AND RECOMMENDED TREATMENT I understand that my orthodontist has recommended that I have a surgical exposure to encourage the eruption of my unerupted tooth. I understand that local anesthetic and possibly intravenous sedation will be required for the procedure. An incision will be made in the gum tissue and any bone covering the crown of the unerupted tooth will be removed to expose the tooth. Certain cases may require the bonding of an orthodontic type bracket to the tooth to help the orthodontist move the tooth into proper position. Suturing may be required as a part of this procedure. 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 the termination of the procedure prior to completion of all of the surgery originally outlined.

EXPECTED BENEFITS The purpose of this procedure is to provide access to the unerupted tooth so that the tooth can be moved into its proper position. If the tooth is able to be positioned properly in the dental arch, my other teeth will be in a more ideal position and I will not have to have a permanent tooth extracted.

PRINCIPAL RISKS AND COMPLICATIONS I understand that not all cases will respond successfully and that the tooth may not erupt into the desired position. In rare cases the tooth/teeth may need to be extracted. I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient, but on occasion, permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient, but on occasion, permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible. 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 results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene and medications that I may be taking. To my knowledge, I have reported to the doctor 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 the doctor and taking all prescribed medications is important to the ultimate success of the procedure. **I will inform my dentist if I am taking or have taken bisphosphonate drugs in the past. I understand that if I am taking oral bisphosphonates, several complications can occur after having this type of procedure and I have discussed it with my dentist.**

ALTERNATIVES TO SUGGESTED TREATMENT My orthodontist has discussed treatment alternatives to my satisfaction.

NECESSARY FOLLOW-UP AND SELF-CARE I understand that I will need to see my orthodontist and Dr. Williamson on a regular basis until the time my tooth is in place and that I should report any irritation, inflammation, or swelling immediately. I am also aware that maintaining excellent oral hygiene in the area will be important to the success of my treatment. In some cases, additional gum grafting will be necessary after the tooth is in its proper position.

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 by improving the resistance mechanics that my orthodontist will need to successfully complete my orthodontic therapy. Due to individual patient differences; however, a doctor 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, including those of my face, 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, for reimbursement purposes or marketing purposes.

I have been fully informed of the nature of the Expose and Bond 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 an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Williamson. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Williamson.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT:

SIGNATURE of patient, parent, or guardian

Date

SIGNATURE of witness

Date