INFORMED CONSENT FOR
GINGIVAL AUGMENTATION SURGERY

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DIAGNOSIS After careful oral examination and study of my dental condition, the Dr. Williamson 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. Williamson has recommended that gingival augmentation procedures be performed in areas of my mouth with significant gum recession. I understand that sedation may be utilized and that a 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 the roof of my mouth or from the adjacent teeth. 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.

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. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, or to prevent or treat root sensitivity or root decay.

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 with increased spacing between the teeth. 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, and or numbness of the gum tissue in the area work was done (5) allergic reactions, and (6) accidental swallowing of foreign matter. The exact duration of any complication cannot be determined, and they may be irreversible. **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.**

FOLLOW-UP I understand that I will need to see Dr. Williamson for a follow-up / post-operative visit. I will then be referred back to my dentist for routine 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 or for reimbursement purposes. My name, however, will not be revealed to the general public without my permssion.

CONSENT FOR SEDATION I understand that anesthetics, medications, and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Mike Williamson of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the procedure. For the same reason I understand that I must inform Dr. Mike Williamson if I am a nursing mother. Because medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can increase with the use of alcohol or other drugs, I have been advised not to operate any vehicle or hazardous device for at least 24 hours or longer until recovered from the effects of the anesthetic, medications, and drugs that may have been given to me for my care. I have been advised not to make any major decisions until after recovery from anesthesia and will have a responsible adult accompany me until I am fully recovered. I have been informed to not drink alcohol or take other nervous system depressants for 24 hours following medication administration. I have been fully advised of and completely understand the alternatives to sedation and accept the possible risks and dangers. I acknowledge the receipt of and understand the preoperative instructions given to me. It has been explained to me and I understand that there is no warranty of guarantee as to any result and/or cure. I have had the opportunity to ask questions about my anesthesia and am satisfied with the information provided to me. I acknowledge that the options for sedation including local anesthesia and conscious sedation have been explained to me. I consent, authorize and request the administration of such anesthetics. I have been made aware of the potential complications associated with the sedation including but not limited to nausea, vomiting, allergic reaction, fluctuations in breathing patterns, heart rhythm and or blood pressure; brain damage and even death. I authorize any corollary procedure, including hospitalization that is necessary to manage my case.

I have been fully informed of the nature of the gingival augmentation 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 gingival augmentation 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 authorize that my treatment and/or financial information may be discussed with family members, guardians, or accompanying chaperones.

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

SIGNATURE of patient, parent, or guardian _____ Date _____

SIGNATURE of witness _____ Date _____