INFORMED CONSENT FOR
PERIODONTAL SURGERY & CROWN LENGTHENING

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DIAGNOSIS After a careful oral examination and study of my dental condition, Dr. Williamson has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gums from the teeth. The pockets caused by this separation allow for greater accumulation of bacteria under the gums in hard to clean areas and can result in 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.

RECOMMENDED TREATMENT In order to treat this condition, Dr. Williamson has recommended that my treatment include periodontal surgery. I understand that 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 gums 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 gums will then be sutured back into position. 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, 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 me 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.

PRINCIPAL 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 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. 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 Dr. Williamson and taking all prescribed medications are 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 I understand that alternatives to periodontal surgery include**:** 1) **No treatment**...with the expectation of possible advancement of my condition which may result in premature loss of teeth, 2) **Extraction** of teeth involved with periodontal disease, 3) **Non-surgical scraping** of tooth roots and lining of the gum (scaling and root planing) with or without medication, in an attempt to further reduce bacteria and tartar under the gumline...with the expectation that this may not fully eliminate deep bacteria and tartar, may not reduce pockets, will require more frequent professional care and time commitment, and may result in the worsening of my condition and the premature loss of teeth.

NECESSARY FOLLOW-UP AND SELF-CARE I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, the doctor may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility. I recognize that natural teeth and appliances 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 the doctor 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 the specific prescriptions and instructions given by the doctor and 2) to see Dr. Williamson and my general dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

CONTINUED

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 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 or for reimbursement purposes. My name, however, will not be revealed to the general public without my permssion.

CONSENT FOR SEDATION 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 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. Michael 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. Michael Williamson if I am a nursing mother. 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 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 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 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