MERIDIAN DENTAL CLINIC

Dentistry Dedicated to Excellence

Consent for Periodontal Osseous Surgery

_____ I hereby authorize Dr. Walker or any Associates
Patient Name

to perform the following procedure:_____ .

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment. The doctor has also informed me that there are certain potential risks associated with this treatment plan or procedure that may occur despite the experience and skill of the doctor.

Osseous (Bone) Surgery: A treatment that involves making an incision in the gum and lifting the gum to expose the roots of the teeth and underlying bone. The unhealthy gum is removed, the teeth and roots are cleaned, the bone may be recontoured, regeneration attempted, and sutures placed. This procedure is performed with local anesthesia. The goal of treatment is to create a positive and healthy periodontal architecture, which promotes your ability to clean the teeth and maintain the tissues. Furthermore, by improving the periodontal health, we may reduce the risk of further gum irritation, disease progression, and tissue infection. This may assist in retaining the gum, bone, and teeth for a longer period of time.

I Understand that **Periodontal Osseous Surgery** includes possible inherent risks such as, but not limited to the following and I agree to accept any and all such risks:

These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
2. Postoperative bleeding requiring additional treatment.
3. Postoperative infection requiring additional treatment.
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings.
6. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
7. Stretching of the corners of the mouth with resultant cracking and bruising
8. The need for additional surgeries.
9. _____

32114 1st Avenue South #200 · Federal Way, Washington 98003
Phone (253) 838-9333 · Fax (253) 517-8766

Bleeding, bruising, swelling: Bleeding may last several hours. If bleeding is profuse,you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.

I understand that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold and appear "longer". I understand that additional procedures are available to protect the exposed areas.

I recognize my medical/dental history is very important. I understand that health conditions and medications that I take can have an impact on my dental surgery. I recognize that it is my responsibility to fully inform my treating dentist(s) of the condition of my health, medications taken, and any and all problems thereto.

I understand that depending on my current dental condition, existing medical problems, or medications I may be taking, these methods alone may not completely reverse the effects of gum disease or prevent further problems.

I realize that unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. This may include the placement of a bone graft material to guide (enhance) bone regeneration prior to completion of the surgery originally outlined. I therefore consent to the performance of such additional or

alternative procedures as may be deemed necessary in the doctor's best professional judgment. I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase the effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

I understand if no treatment is rendered or if active treatment is interrupted or discontinued, my periodontal condition would likely continue and worsen. This may result in pain, swelling, bleeding, infection, recession, mobility, decay, staining, bone loss, and tooth loss. Untreated periodontal disease may also affect on your systemic health. Studies have shown exacerbation of systemic conditions such as cardiovascular disease, diabetes, and respiratory disease. Pregnant women may be at an increased risk of a premature and low birth weight baby.

I have been given the opportunity to ask any questions regarding the nature and purpose of this treatment known as **Periodontal Osseous Surgery** and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorized Dr. Walker and his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications. Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary. I also verify that I have provided a complete and accurate medical history that includes all medications, drug use, allergies, previous surgeries, and pregnancyinformation and history.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase the effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask the doctor or staff if you have any questions.

_____

Patient, parent or guardian

_____ _____

Doctor Date

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