LUXURY SMILE

Studio

ESTD 2009

INFORMED TREATMENT CONSENT

SURGICAL PERIODONTAL TREATMENT

Patient name _____ Date _____

Proposed Treatment _____

Facts for Consideration:

Patient's initials

____ Dental x-rays may be taken to check the condition of the bone that supports your teeth. A thorough examination of your oral cavity will be done measuring the pockets under the gums surrounding your teeth to determine which periodontal treatment(s) your periodontal condition requires.

____ Surgical periodontal treatment involves cutting and lifting small areas of the gum tissue to expose the bony defects around the teeth. Surgical removal of the diseased gingiva (gum tissue) to reduce or eliminate periodontal pockets may occur. It may also include scaling and root planing of the root surfaces exposed during the surgery. Lastly, surgical periodontal treatment may include resection, reduction, and/or re-contouring of the hard (osseous/bone) and soft (gingival/gum) tissues. A periodontal dressing may be placed over the area of surgery to aid in healing.

____ I have been advised that bone grafting or other regenerative products may be utilized in areas of my mouth associated with gum pocketing and/or recession. It has also been explained to me that this is a procedure may involve surgical grafting of bone by removing a piece(s) of bone from another area of my body, requiring another surgical site, or using a commercial source from another human, animal, or synthetic source. The regenerative material may be used in a block form over a large area or in particulate form for smaller areas. I acknowledge that I had an opportunity to discuss these options and my choice with the doctor before consenting to this treatment, procedure or surgery.

____ The success of my treatment depends in part on the patients' effectiveness in maintaining optimal oral hygiene (ie.brushing, flossing, etc.) daily, receiving regular dental care and cleanings, and periodontal maintenance as directed. I understand my compliance is paramount to the success of any surgical procedure. I agree to follow post-operative instructions given to me meticulously, and I agree to follow a healthy diet, avoid tobacco products, and follow proper home care.

Benefits of Bone Grafting and/or Regenerative Surgery, Not Limited to the Following:

_____ The goal of bone grafting and/or regenerative surgery is to "grow" bone. This may be done around natural teeth, areas without teeth, or dental implants. This procedure may or may not be in conjunction with other procedures on the same day. This may be necessary for possible dental implant placement either at the same time as this surgery or a later date. Additionally, the purpose of this surgery may be to help build a restorable jaw ridge for better esthetics, form, or function for other reasons. Benefits of Surgical Periodontal Treatment, Not Limited to the Following:

_____ Surgical periodontal treatment can help create a clean environment in which your gums can heal; help to reduce the chances of further gum irritation or infection; make it easier for you to keep your teeth clean; and improve your chance to retain teeth and their function. This course of treatment may help improve your condition and prevent this disease from progressing and/or spreading.

Risks of Surgical Periodontal Treatment, Not Limited to the Following:

_____ I understand that my gums may bleed or swell, and I may experience discomfort for several hours or days after the anesthesia wears off. This may be treated with pain medication. I will notify the doctor or the office if conditions persist beyond a few days.

_____ I understand that surgical periodontal treatment involves contact with bacteria and infected tissue in my mouth. I may experience an infection, which may be treated with antibiotics. I will immediately contact Dr. Ngo and the office if I experience fever, chills, sweats or numbness.

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore, and it may make it difficult for me to open wide for several days. This can occasionally be an indication of a further problem. I must notify Dr. Ngo if this or other jaw function concerns arise.

_____ I understand that as my gum tissue heals, it may shrink and expose some of the root surface. This could make my teeth more sensitive to hot, cold, or other liquids/foods. I also understand that following treatment, I may have spaces between my teeth, which could trap food particles and require special maintenance. I understand additional surgical procedures may be available to protect the sensitive areas.

_____ I understand these surgical procedures alone may not completely reverse the effects of my periodontal disease or prevent future problems. Teeth that become loose as a result of periodontal disease or surgery may need to be extracted, which may require replacing the teeth with a fixed or removable bridge, denture, or dental implants.

_____ I understand that I will receive a local anesthetic by injection and/or other medication(s). In rare instances, patients have a reaction to the anesthetic, which may require emergency medical attention or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury occurs resulting in loss of feeling of the teeth, chin, skin, lips, gums, or tongue. Additionally, partial loss of taste can result from an injection.

_____ I understand that all medications have the potential for side effects, unintended reactions, and drug interactions. Therefore, it is critical that I tell Dr. Ngo of all medications I am currently taking. If there have been any changes in my medications or medical history, I understand that I must tell Dr. Ngo directly and immediately.

_____ I understand that smoking, using tobacco products, and alcohol intake affect my ability to have normal gum and/or bone healing and may limit the potential for a successful outcome of my surgery. I agree to follow Dr. Ngo instructions related to daily care of my mouth, teeth and gums.

_____ I understand that there may be post-operative bleeding, swelling, pain, infection, facial discoloration, temporary or, on occasion, permanent tooth sensitivity to hot, cold, sweet, or other liquids/foods. A temporary or permanent numbing of the surgical area may occur affecting my teeth, lips, skin, chin and tongue which can possibly affect my sense of taste. I understand that I may see changes in the appearance of my gums. They may be in a different position on the roots or there may be spaces between the teeth that are larger. I also understand that there may be a need for a additional procedures if the initial surgery is not entirely successful.

Consequences If No Treatment Is Administered, Not Limited to the Following:

_____ I understand that if no treatment were administered or ongoing treatment was interrupted or discontinued, my periodontal condition can progressively worsen. This could lead to further inflammation and infection of teeth, gums, and/or bony tissues, tooth decay above and below the gum line, deterioration of bone surrounding the tooth, and the loss of teeth.

Alternatives to Suggested Treatment:

_____ I understand that alternatives to periodontal surgery may include:

1. No treatment with the expectation that chronic inflammation results in the advancement of bone loss and possibly the premature loss of teeth;
2. Non-surgical scraping of tooth roots and lining of the gum (root planning and curettage) with the expectation that this will result in only a partial and temporary reduction of inflammation and infection and will not reverse bone loss, will require more frequent professional care, and may result in the worsening of my condition and possibly the premature loss of teeth;
3. Extraction of teeth involved with periodontal disease (which may need replacement with bridges, crowns or dental implants).

_____ I discussed alternative treatments including, but not limited to, those listed above with Dr.Ngo.

Check only one of the boxes below that applies to you:

☐ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above. I understand that no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve my periodontal or dental condition(s).

☐ I refuse to give my consent for the proposed treatment as described above and understand the potential consequences associated with this refusal.

Patient's or Patient's Representative's Name _____

Patient's or Patient's Representative's Signature _____ Date _____

I attest that I have discussed the risks, benefits, consequences, treatment options, and alternatives to periodontal surgical treatment with my patient. My patient had the opportunity to discuss these topics and ask questions, and I believe my patient understands what has been explained.

Doctors Name _____

Doctor's Signature _____ Date _____

THANK YOU

FOR CHOOSING LUXURY SMILE STUDIO!

Dr. Ngo & Team