**MOHAMAD ELAZIZI, B.D.S., M.S.**

# INFORMED CONSENT FOR GINGIVAL GRAFT SURGERY

**Diagnosis:** After a careful oral examination, radiographic evaluation and study of my dental condition, my periodontist has advised me that I have an insufficient amount of attached gingiva (firm gum tissue) around my tooth/teeth. 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 a sufficient width of firm, attached gum tissue around the roots of the tooth/teeth to withstand the irritation they may cause. Gingiva improves the appearance and protects the roots of the tooth/teeth. It may also be placed to facilitate orthodontic tooth movement.

**Recommended Treatment:** My periodontist has recommended that gingival grafting be performed in areas of my mouth with significant gum recession. I understand that a local anesthetic will be administered to me as part of the treatment. During the procedure, the following will be performed:

- A thin strip of gum from the roof of my mouth or from the adjacent teeth will be surgically transplanted.
- The existing gum tissue around the tooth/teeth to be grafted will be excised back so that the transplanted strip of gum can be sutured in place.
- The transplanted strip of gum will be placed at the base of the existing gum or placed so as to partially cover the tooth root surface exposed by recession.
- A periodontal dressing may be placed.

**Expected Benefits:** The purpose of gingival grafting is to create an adequate amount of attached gum tissue to reduce the likelihood of further gum recession, to enhance the appearance of the teeth and gumline, or to prevent/treat root sensitivity or root decay. The entire exposed tooth root caused by existing gum recession may not be totally re-covered.

**Principal Risks and Complications:** I understand that some patients do not respond successfully to gingival grafting. If a transplant is placed so as to partially cover the tooth root surface exposed by recession, the gum placed over the root may shrink back during healing. In such cases, the attempt to cover the exposed root surface may not be completely successful and the grafting may result in additional recession with increased spacing between the teeth. Complications may result from the gingival grafting, drugs, or anesthetics. These complications include, but are not limited, to the following: post-surgical infection; bleeding; swelling; pain; facial discoloration; tooth sensitivity to hot, cold, sweet or acidic foods; numbness of the jaw, lip, tongue, chin, or gum; cracking or bruising of the corners of the mouth; tooth looseness; 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.

I understand that there is no method that will accurately predict or evaluate how my gum and bone will heal. There may be a need for a second procedure if the initial results are not satisfactory. In addition, the success of gingival grafting 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 my periodontist any prior drug reactions, allergies, diseases, symptoms, habits or conditions that might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed is important to the ultimate success of the procedure.

**Alternatives to Suggested Treatment:** I understand that alternatives to gingival grafting include no treatment, continued monitoring and modification of brushing technique. All of these could lead to continued recession.

**Necessary Follow-Up and Self-Care:** I understand that I need to return for follow-up appointments for care and monitoring of the healing process. Smoking and alcohol intake may adversely affect healing and limit the successful outcome of my procedure. Smokers have more grafts fail than non-smokers. I understand that failure to follow such recommendations regarding my gingival graft(s) could lead to ill effects, which would become my sole responsibility.

In addition, existing dentistry can be an important factor in the success or failure of gingival augmentation. I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner.

To my knowledge, I have told my periodontist about any pertinent medical conditions, allergies (especially to medications or sulfites) and medications I am taking, including over-the-counter medications such as aspirin.

***(OVER)***

I know that it is important to: **(1)** abide by the specific prescriptions and instructions given; **(2)** see my periodontist for post-operative check-ups; **(3**) not smoke or use smokeless tobacco; **(4)** perform excellent oral hygiene as instructed; **(5**) have the graft area reshaped, if needed; and **(6)** have my prosthetic appliance(s) adjusted if necessary.

**Females Only:** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use an additional form of birth control along with my birth control pills for one complete cycle after a course of antibiotics is completed.

**Administration of Local Anesthetic:** Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs until fully recovered from their effects.

**No Warranty or Guarantee:** There is no method that will accurately predict or evaluate how my gum and bone will heal. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases it should be, however, due to individual patient differences there can never be a certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including possible loss of teeth despite the best of care.

**Communication with Insurance Companies and Dental/Medical Providers:** I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carrier(s), the doctors' billing agency, my general dentist, and any other health care provider involved with my case who may have a need to know about my dental treatment.

## PATIENT CONSENT

**I certify that I have been fully informed of the nature of gingival graft surgery, the procedure to be utilized, the risks and benefits of such surgery, the alternative treatments available, the necessity for follow-up and self-care, and that there are no guarantees. I have had the opportunity to ask questions in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of gingival grafting 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 my periodontist.**

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE I SIGNED IT AND CONSENT TO GINGIVAL GRAFT SURGERY.**

_____ _____
Signature of Patient (Parent/Guardian) Date

_____
Printed Name of Patient (Parent/Guardian)

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

**Initial and Date If Applicable:**

Patient: _____; _____; _____
2nd Surgery 3rd Surgery 4th Surgery

Witness: _____; _____; _____
2nd Surgery 3rd Surgery 4th Surgery