ORANGE PERIODONTICS
AND DENTAL IMPLANTOLOGY

Richard K Parris DDS, Sepi Lee DDS MS, Cliff Lee DMD MS

CONSENT FOR SOFT TISSUE AUGMENTATION

An explanation of your need for soft tissue augmentation, the purpose and benefits, and the possible complications as well as alternatives to its use was discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Suggested Treatment: I have been informed of the need for soft tissue augmentation. The reasons for this have been explained to me. The primary goal of the procedure is to thicken the gums to make them more resistant to future recession. Obtaining root coverage is a desirable secondary outcome that may be able to be achieved.

Description of the Procedure: After anesthetics have numbed the area to be operated, surgical reflection of the gums will be accomplished in the recipient area. Tissue may be harvested from a donor site, such as the palate, tuberosity, or edentulous ridge, and/or allogenic tissue may be used from a donor bank. Donor tissue will be sutured to the recipient area, and measures will be taken to reduce bleeding from the recipient area, and from the donor area if applicable.

Risks Related to the Suggested Treatment: Risks related to tooth removal surgery might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient but on occasion permanent numbness of the lip, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, sensitivity to hot or cold or sweets or acidic foods, or shrinkage of the gum upon healing. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing/aspiration of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetics.

Alternatives to the Suggested Treatment May Include:

1. No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including, but not limited to, bone loss, pain, infection, damage to the support of adjacent teeth.
2. A dental restoration on the exposed root surface.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will be completely successful in eradicating all pre-existing symptoms or complaints. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth by reducing the problems associated with this tooth/these teeth. However, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement, despite the best of care.

Consent to Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such

additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake and improper oral hygiene and/or diet may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored, and the doctor can evaluate and report on the success of the surgery.

Supplemental Records and Their Use: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to tooth extraction and the simultaneous use of bone grafting to attempt ridge augmentation as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

_____	_____	_____
Patient's Signature	Date	Patient's Name

_____	_____
Signature of Witness	Date