PERIODONTAL SURGERY

Patient Name: ____
Date: ____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing Periodontal Surgery, treatment involving the gum and tissue supporting the teeth, there are certain risks and the potential for unsuccessful results. In order to minimize these outcomes, once treatment begins complete cooperation and participation is necessary to include follow up care.

After careful examination, the existence of periodontal disease has been noted. The progression of the disease has been explained to me which can include bone loss, eventual tooth loss and possibly other associated diseases such as heart disease.

Risks associated with treatment included but are not limited to the following:

- Future extraction of the teeth involved if the healing process is not achieved
- Sensitivity and soreness post operatively to hot and cold sensations, and sweet or sour foods
- Bleeding of the gums during or after treatment
- Recession of the gums which might increase sensitivity, create aesthetic or cosmetic changes or widening of the tooth spaces which can cause food to be trapped
- Broken instruments during the procedure may require surgical intervention
- Postoperative infection which may require immediate additional treatment
- Soreness/cracking in the corners of the mouth
- Mobility of the teeth where bone loss has occurred

The risks of not having this treatment as recommended include but are not limited to:

- Pain
- Bleeding
- Swelling
- Mouth odor
- Tooth mobility and/or tooth loss
- Infection which could lead to other health issues

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with this dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature: ____
Patient Printed Name: ____
Date: ____

Doctor's Signature: ____
Date: ____

SAMPLE