ClearCare
Periodontal & Implant Centre

2nd Floor – 191 River Avenue
Winnipeg, MB, R3L 0B1
Phone: 204.421.9236
Fax: 204.421.9206
Email:info@clearcareperio.com

CONSENT FOR PERIODONTAL SURGERY

This is my informed consent for the following procedure as previously explained to me:

o Pocket reduction surgery:

_____

o Crown lengthening surgery:

_____

During these procedures, my gums will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped, and bone regenerative material may be placed around my teeth. My gum will then be sutured back into position, and a periodontal bandage or dressing may be placed.

Expected Benefits. The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible or to provide better access for my general dentist for restorative procedures. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

Principal Risks and Complications. I understand that a small number of patients do not respond successfully to periodontal surgery, and in such cases, the involved teeth may eventually be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur, despite the best of care.

I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent tingling/ numbness of the jaw, lip, tongue, teeth, chin or gum; jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkages of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, 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.

Necessary Follow-Up Care And Self-Care. I understand that it is important for me to continue to see my regular dentist. I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum and bone healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by my doctor and (2) to see my doctor and my family dentist for periodic examination and preventive treatment.

I have had the opportunity to discuss my medical and health history, including any serious problems and/or past surgeries. I agree to cooperate with the recommendations of my doctor while I am under their care, realizing that any lack of cooperation may result in a less than optimal result.

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my doctor. I hereby consent to the performance of periodontal surgery as presented to me during consultation and as described in the treatment plan.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

(DATE) (Printed name of patient or guardian)

_____

(Signature of patient or guardian)

_____

(Signature of Witness)