Informed Consent For Gum Pocket Reduction Surgery (Periodontal Osseous Resective Surgery)

Diagnosis:

After a careful oral examination, radiographic evaluation and study of my dental condition, the dentist has advised me that I have bone loss and/or gum pockets around my teeth from periodontal disease. Various forms of periodontal diseases are fairly common. I understand that periodontal disease weakens the support of my teeth by separating the gum from my teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further loss or erosion of bone and gum tissue supporting the roots of my teeth. If left untreated, periodontal disease can progress and cause me to lose my teeth and can have other adverse consequences which may include systemic problems such as cardiovascular disease.

Recommended Treatment:

The dentist has advised me that I would benefit from periodontal osseous surgery (gum and supporting bone surgery). I understand that local anesthetic will be administered as part of the surgery. I further understand that antibiotics and other substances may be applied to the roots of my teeth during surgery. The gum will be trimmed and pulled away from the teeth to permit better access to the roots and supporting bone in my jaw. The infected and inflamed gum tissue will be removed and the root surface will be thoroughly cleaned. Bone irregularities will be reshaped. This will require additional bone to be removed to provide smoothness to the architecture of the bone which will allow for the area to be cleansed easier and promote better healing of the gums after surgery. The gum will then be sutured back closer to the new bone level. The surgery will make it look like the gum has receded, making the teeth look longer and resulting in spaces between them as the gum papilla (pointy part of the gum between the teeth) is lowered.

Expected Benefits:

The purpose of periodontal osseous surgery is to reduce infection, inflammation and flatten bone deformities created by periodontal disease to reduce the gum pockets. This surgery is intended to help me significantly improve the chances of keeping my teeth in the operated area and to make my oral hygiene more effective. It should also enable your hygienist to better clean my teeth.

Principal Risks and Complications:

I understand that this periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to;

1) infection, bleeding, swelling and pain, facial discolouration
2) Numbness of the jaw, lip, tongue, teeth, chin, or gum or jaw joint pain which may be transient or permanent
3) Teeth sensitivity to hot, cold, sweets
4) Shrinkage of the gum (increased recession) ***will*** occur resulting in elongation of the teeth and greater spaces between the teeth
5) Muscle spasms due to opening for the duration of the procedure, cracking of the corners of the mouth
6) There is no method that will accurately predict or evaluate how my gum and bone will heal. In addition, the success of periodontal procedures can be affected by medical, nutritional problems, smoking, and alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.
7) Possible root canal of the treated teeth due to excessive sensitivity
8) Loosening or increased loosening of my teeth in the area which may be permanent
9) Loss of the teeth treated as gum disease is a progressive disease with no cure

Alternatives to Suggested Treatment:

1) No treatment with the expectation of possible advancement of my gum disease which may result in loss of teeth
2) Non-surgical cleaning of tooth roots and lining of the gum (root planning and scaling), with or without medication in an attempt to reduce bacteria and tartar under the gum line with the expectation that this will not fully eliminate deep bacteria and calculus, and likely will not reduce gum pockets. This will require frequent cleanings with your hygienist.
3) Extraction of teeth involved with periodontal disease may be required sooner in the future if no treatment or a non-surgical approach is chosen than if the surgical recommended treatment is chosen.

No Warranty or Guarantee:

I acknowledge no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help keep my teeth longer. 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 the possible loss of certain teeth, despite the best of care.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS:

I understand that excessive smoking and/or alcohol intake 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 dentist can evaluate and report on the success of surgery.

SUPPLEMENTAL RECORDS AND THEIR USE:

I consent to photography, video and x-rays of my oral structures as related to these procedures as required.

PATIENT'S CONSENT: I have read and fully understand the procedure that has been proposed to me and the reason for this treatment. Dr. Tam has consulted on all risks and benefits of this treatment and I have been given the opportunity to ask any questions related to this procedure which have been answered adequately. After thorough consideration, I give my consent to have this treatment completed.

I **HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.**

Patient or Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

Dentist: _____Date:_____