Informed Consent for
Gingival Augmentation Surgery

Diagnosis: After a careful examination and study of my dental condition, the periodontist has advised me that I have significant gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gum line or crowns with edges under the gum line, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

Recommended Treatment: In order to treat this condition, the periodontist has recommended that Gingival Augmentation procedures be performed in areas of my mouth with significant gum recession. This surgical procedure involves the transplanting of a thin strip of gum from the roof of my mouth, from the adjacent teeth, or from donor tissue (allograft). The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed so as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

Expected Benefits: Gingival Augmentation creates an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Gingival Augmentation also covers exposed root surfaces, to enhance the appearance of the teeth and gum line, or to prevent or treat root sensitivity or root decay.

Risks Related to the Procedure and Unforeseen Conditions: I understand that a small number of patients do not respond successfully to Gingival Augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession with increased spacing between the teeth. I understand that complications may result from Gingival Augmentation. Risks include, but are not limited: post-surgical infections; bleeding, swelling, and pain; facial discoloration; transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods; allergic reactions; and accidental swallowing of foreign matter. Unforeseen Conditions 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.

Alternatives to Suggested Treatment: The periodontist has explained alternative treatments for my gum recession. These include, but are not limited to: (1) not proceeding with the recommended treatment, continued monitoring for progressive recession, and modification of technique for brushing my teeth.

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 also understand that failure to follow daily care instructions or report for follow-up appointments as needed may lead to further risks or complications

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that proposed treatment will be successful. There is risk of failure, relapse, need for additional treatment, or even worsening my present condition, including the possible loss of certain teeth, despite the best care.

Supplemental Records and Their Use: I consent to the use of photography, video recording, and/or X-rays of my oral structures for both the above procedure(s) and educational use in lectures or publications, provided my identity is not revealed in compliance with HIPAA.

I, _____, understand the risks involved with Gingival Augmentation and I release Dental TLC and any Dental TLC employees, agents or independent contractors from any liability related to the Gingival Augmentation.

_____ **Date: _____**

Signature

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