Etienne P. Lacrampe, DMD
Diplomate of the American Board of Periodontology
Practice Limited to Periodontics and Dental Implants

CONSENT TO PERIODONTAL SURGERY

I _____(name of patient, or if a minor, parent's name) hereby authorize Dr. Lacrampe to perform the following surgical treatment(s) as indicated below.

Osseous Surgery

I understand that I have a form of periodontal disease that has caused damage to the soft tissue and/or bone around my teeth and is endangering the health of my oral tissues. This disease, if left untreated, is generally non-reversible and can be progressive, leading to further damage and possible loss of my teeth.

I also understand that a variety of surgical procedures are used to treat periodontal disease. While these surgical procedures are generally successful, I understand that no guarantee, warranty, or assurance has been given me that the proposed treatment will be curative and/or successful.

It has been explained to me that long-term success of treatment requires my cooperation and performance of effective plaque control (home care) on a daily basis. Equally important are periodic periodontal maintenance visits at a dental office after the proposed surgical treatment is performed. This is because most periodontal disease is chronic in nature and requires continuing treatment to keep it under control. Periodontal disease is rarely curable even with the most effective treatment.

I further understand that the rate of the progression of the disease is variable and unpredictable, but if no treatment is rendered, my present periodontal condition will probably worsen in time, which may result in premature tooth loss.

I have been informed that other possible alternative methods of treatment include: no treatment, non-surgical treatment (root planning followed by periodic maintenance), other surgical treatment procedures, or extraction.

Although complications from periodontal surgery are rare, they can occur. The most common complications are as follows: post surgical discomfort, bleeding, swelling, tooth sensitivity, infection, gum recession (shrinkage) with tooth elongation, temporary increased tooth looseness, food impaction between teeth after eating, unaesthetic exposure of crown margins, and/or
(specify):_____

I CERTIFY THAT I HAVE FULLY READ AND UNDERSTAND THE ABOVE CONSENT TO THE SURGICAL TREATMENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS OR REQUEST A MORE DETAILED EXPLANATION, AND TO DISCUSS WITH THE DOCTOR PAST MEDICAL HEALTH HISTORY INCLUDING ANY SERIOUS PROBLEMS, INJURIES, OR ALLERGIES.

Date:_____ Patient's signature:_____

Date:_____ Dr. Lacrampe's Signature:_____