CONSENT FOR GINGIVAL AUGMENTATION SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, Dr. Victor Sun 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 teeth.

Recommended Treatment: In order to treat this condition, Dr. Victor Sun has recommended that gingival augmentation procedures be performed in areas of my mouth with significant gum recession or insufficient attached gum. I understand that a local anaesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplanting of a thin strip of gum from the roof of my mouth or from the adjacent teeth. A periodontal bandage or dressing may be placed. A referral to a periodontist has been offered but I elect Dr. Victor Sun to perform the procedure. I understand that Dr. Victor Sun is a general dentist who has received extra training for gingival augmentation procedures.

Expected Benefits: The purpose of gingival augmentation is to create an amount of gum tissue adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, or to prevent or treat root sensitivity.

Principal Risks and Complications: 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 teeth.

I understand that complications may result from gingival augmentation, drugs or anaesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, allergic reactions, and accidental swallowing of foreign matter.

There is not method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. The success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

Alternative To Suggested Treatment: Dr Victor Sun has explained alternative treatment for my gum recession. These include no treatment, continued monitoring for progressive recession, and modification of technique for brushing my teeth.

Necessary Follow-up: I understand that it is important for me to continue to see Dr. Victor Sun. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy.

I will need to come for appointments following surgery so that my healing may be monitored and so Dr.Victor Sun can evaluate and report on the outcome of surgery upon completion of healing.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, Dr. Victor Sun cannot predict 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.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND HEREBY CONSENT TO THE PERFORMANCE OF GINGIVAL AUGMENTATION SURGERY AS PRESENTED TO ME DURING CONSULTATION AND IN THE TREATMENT PLAN PRESENTATION AS DESCRIBED IN THE DOCEMENT.

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(date) (signature of patient, parent or guardian)

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(date) (signature of witness)