Consent for Soft Tissue Graft

After a careful oral examination and study of my dental condition, my periodontist has advised me that I have an area or areas of gum recession in my mouth. I understand that gum recession can result in the exposure of the roots of my teeth to the oral cavity. This exposure may lead to an unaesthetic appearance of my teeth, sensitivity to cold or hot fluids, and may increase the chance of root decay.

I have been advised to have a surgical procedure to improve the condition of my receded gum tissues. The surgery is intended to help thicken the gum tissue and cover all or a portion of the exposed root. I will be administered a local anesthetic with a vasoconstrictor which will make my mouth numb, decrease bleeding, and avoid pain. The root surfaces will be thoroughly cleaned and may be reshaped with hand instruments to reduce their curvature. I understand that incisions will be made around my teeth so that my gums can be reflected to permit better access to the roots and recipient area. A soft tissue graft will then be secured over the previously exposed roots and secured into place with sutures. My gum tissue will then be sutured back into position over the graft. I understand that my gum tissue may or may not cover all of the graft once it is secured in place.

I understand that the graft will be harvested from the roof of my mouth. Incisions will be made on the roof of my mouth to permit the release of the soft tissue graft. In some cases, donor soft tissue may be used instead of my own connective tissue. I have discussed the risks and benefits of any type of donor tissue and (do/do not) authorize its use during my surgery.

I understand that some patients do not respond successfully following soft tissue grafts. In such cases, the involved teeth may experience little to no root coverage, or may demonstrate an increase in root exposure. I understand that complications may result from periodontal surgery, drugs, or anesthetics administered. These complications include but are not limited to: post-surgical infection, bleeding, bruising, swelling and pain, teeth appearing longer than before, temporary or in some cases, permanent tooth mobility, temporary or in some cases, permanent tooth sensitivity to hot and/or cold fluids, clicking or pain in the jaw joints, unaesthetic exposure of crown margins, unaesthetic gaps or spaces located between the teeth, food impacted between teeth after meals, avulsion or rejection of the graft, and transient, but on occasion, permanent numbness of the jaw, lip, tongue, teeth, chin or gums.

I understand that following my surgery, my teeth should be maintained in a clean, hygienic manner. I will need to keep any post operative follow up appointments so that my healing may be monitored. Failure to follow a maintenance program recommended to me by my periodontist may result in relapse of my present condition.
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, a periodontist cannot predict certainty of success.

There is a risk of failure, relapse, additional treatment, or even worsening of my current condition. I understand that if no treatment is rendered, my present condition may worsen and may result in premature tooth loss. I have been informed that other alternative and/or supplemental methods of treatment exist for my condition, including but not limited to: prophylaxis (dental cleaning), scaling and root planing, tooth colored filings over the exposed root, application of desensitizing agent, and occlusal adjustments (selective adjustment of the teeth). However, worsening recession may occur sooner or faster without the recommended treatment.

I have been fully informed about the advantages, disadvantages, risks and benefits of this surgical procedure. I also understand the necessity for follow-up, periodontal maintenance, and home care. I have had the opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT. I CHOOSE TO PROCEED WITH THE SOFT TISSUE GRAFT SURGERY FOR TREATMENT OF MY PERIODONTAL CONDITION AS DESCRIBED ABOVE.

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(Printed Name of Patient/Guardian)

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(Signature of Patient/Guardian)

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(Printed Name of Witness)

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(Signature of Witness)