PERIODONTAL IMPLANTICS

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CONSENT FOR PERIODONTAL PLASTIC SURGERY

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist (Dr. Lueder) 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 gumline or crowns with edges under the gumline, 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, my periodontist has recommended that periodontal plastic surgery (gum grafting) be performed in areas of my mouth with significant gum recession. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. This surgical procedure may involve the transplanting of a thin strip of gum from elsewhere in my mouth or from a tissue bank (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: The purpose of periodontal plastic surgery is to create an amount of attached 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 or root decay.

Principal Risks And Complications: I understand that a small number of patients do not respond successfully to periodontal plastic surgery. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed so as to partially cover the tooth root surface exposed by the recession may shrink back during the 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 or with increased spacing between the teeth. I understand the primary purpose of my periodontal plastic surgery may be to thicken the gums only and recession coverage may not be attempted.

I understand that complications may result from periodontal plastic surgery or from anesthetics. These complications include, but are not limited to, (1) post-surgical infection, (2) bleeding, swelling, and pain, (3) facial discoloration, (4) transient, or on occasion permanent, tooth sensitivity to hot, cold, sweet, or acidic foods, (5) allergic reactions, and (6) accidental swallowing of foreign matter. The exact duration of any complications cannot be determined and may be irreversible.

There is no 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. In addition, the success of periodontal plastic surgery can be affected by, (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) clenching and grinding of teeth, (5) inadequate oral hygiene, (6) trauma to or movement of the grafted area, and (7) medications that I may be taking. To my knowledge I have reported to Dr. Lueder any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by Dr. Lueder and his staff and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives To Suggested Treatment: Dr. Lueder has explained alternative treatments for my gum recession and modification of the technique for brushing my teeth.

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal plastic surgery. I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my treatment so that my healing may be monitored and so that Dr. Lueder can evaluate and report on the outcome of surgery. I know that it is important to abide by the specific prescriptions and instructions given by Dr. Lueder and his staff and to see Dr. Lueder and my dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

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. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, Dr. Lueder cannot predict certainty of success. There is risk of failure, relapse, need for additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records: I authorize photos, slides, x-rays, videos, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and/or reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

PATIENT CONSENT

I have been fully informed of the nature of periodontal plastic surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Lueder. After thorough deliberation, I hereby consent to the performance of periodontal plastic surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Lueder.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Date	Printed name and signature of patient, parent or guardian
Date	Printed name and signature of witness
Date	Jacob C. Lueder, DDS, MS Member – Jacob C. Lueder, DDS, MS, PLLC