Center for Implant Dentistry

CONSENT FOR CONNECTIVE TISSUE GRAFT

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EXPLANATION OF DIAGNOSIS: I have been informed to the presence of significant gum recession associated with some of my teeth. I understand that it is important to have a sufficient width of gum (attached gingiva) around the base of the teeth (at the gum line) to prevent bacterial invasion and subsequent inflammation, bone loss, and possible tooth loss. I also understand that where there are fillings at the gum line or crowns (caps) with edges under the gum line, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or caps or the material from which they are made do not cause significant irritation to the gum and supporting bone.

PURPOSE OF CONNECTIVE TISSUE GRAFTING: I have been informed that the purpose of connective tissue grafting is to create an adequate zone (width) of attached gum tissue so as to prevent the likelihood of further gum recession and provide gum attachment – a seal against bacterial and food invasion. In addition, it can in some case result in the reduction of recession of the gum line about a tooth or teeth.

SUGGESTED TREATMENT: It has been suggested that connective tissue grafting be performed in areas of my mouth where I have significant gum recession. It has been explained that this is a surgical procedure involving the removal of a thin strip of gum from inside the gum on the roof of my mouth and transplanting it to the area of significant gum recession. Then it is placed inside a gum line flap (pouch) that has been created by releasing the edge of the gum from about a tooth or teeth. The gum flap and tissue graft are then sutured to secure them in place in such a manner that the new edge of the gum partially or completely covers the tooth root surface exposed by the recession. If the latter is attempted, I understand that the gum placed over the root may shrink back during healing and that the attempt to cover the exposed root surface may not be completely successful.

RISKS RELATED TO SUGGESTED TREAT,MENT: While this could be considered a low risk procedure, risks related to connective tissue grafting might include, but are not limited to, post-operative bleeding, swelling, pain, infection, facial discoloration, transient or, on occasion, permanent tooth sensitivity to hot or cold, sweets or acidic foods. Risks related to the local anesthetics might include, but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetics.

ALTERNATIVES TO THE PROCEDURE: These may include: (1) the use of other plastic surgical procedures to attain a similar result; (2) no treatment, with the expectation of chronic inflammations resulting in the advancement of recession which is commonly associated with increased sensitivity of the teeth to temperature extremes and other irritants, increased risk of decay in root surfaces exposed by the recession and possibly the premature loss of teeth; (3) attempts to insulate teeth to control sensitivity by placing fillings in or on root surfaces with the expectation of further recession as a result of this procedure; (4) non-surgical scaling of tooth roots and lining of the gum (root planning and curettage) with the expectation that this will result in only a partial and temporary reduction of inflammation and infection, will not stop recession and will require more frequent professional care, and may result in the worsening of my condition and the premature loss of teeth; (5) extraction of teeth involved with recession and a lack of attached gum tissue.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infection or further bone loss or gum recession. I tis anticipated that the surgery will provide benefit in reduction the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient difference, however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include but are not limited to, performance of another plastic surgical procedure to attain a similar result, or termination of the procedure prior to completion of all of the surgery as may be deemed necessary in the best judgment of the treating doctor.

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 aerobic exercise can cause the loss of a clot with bleeding and possibly reduced success to the outcome of this surgical procedure. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of my surgery.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

PATIENT'S ENDORESEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to connective tissue graft surgery as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

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Patient's Signature	Date	Patient's Name (please print)
Signature of Patient's Guardian	Date	Relationship to Patient
Signature of Witness	Date	