KENNESTONE PERIODONTICS, P.C.

Dental Implant and Periodontal Care Specialist

Periodontal Care  *Dental Implants*

"A Team Approach"

CONSENT TO PERIODONTAL (GUM) SURGERY

I hereby authorize Doctor Lee H. Silverstein (hereinafter called "Doctor") to perform the surgery described below upon:

(Name of Patient) _____

Proposed Operation (s) : _____

☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left

I have been informed that the purpose of the operation is to surgically treat my gum tissues, teeth or supporting jawbones, and/or to rebuild lost tissues.

This type of surgery is performed after the area to be treated is anesthetized in the standard manner with local injections of anesthetic solution(s), which may contain vasoconstricting drugs.

If I chose to have Nitrous Oxide and Oxygen analgesia used to relax me, I acknowledge that I have had the effects explained and understand that I will be able to leave and drive under my own power once the gas has been cleared from my system.

If I have requested or agreed to the use of sedative drugs (orally or intravenously) before surgery, I agree that I will not consume anything by mouth for at least 6 hours before the procedure and that I will not drive myself home after the surgery or operate any device which requires complete control of my mental faculties until such agents have cleared my system. Furthermore, I have arranged for post-operative transportation by:

(Name of Driver) _____

I further acknowledge that I have made arrangements for an adult to care for me until the sedative agents have cleared from my system.

In the event that extraction of any teeth is deemed advisable by the Doctor due to conditions visualized and determined during the surgery, I hereby consent to all such extractions.

If any unforeseen conditions should arise in the course of the operation, calling for the Doctor's judgment or for procedures in addition to or different from those above mentioned, I further authorize the Doctor to do whatever he may deem advisable and in my best interest. I understand that there may be additional fees associated with such additional treatment(s).

Furthermore, I have been informed that alternatives to surgical treatment include: doing nothing, extracting the involved teeth or receiving frequent, repetitive deep scaling and root planings to attempt to slow down the disease process. However, I have agreed to have the surgical treatment performed in order to more directly treat the above-mentioned areas.

If Guided Tissue Barrier Materials are used in conjunction with my therapy, I understand that additional surgery may be required for their removal at a later date.

_____
initials

2501 Windy Hill Road
Suite 200
Marietta, GA 30067
(770) 952-5432
(On Windy Hill Road between I-75 and Hwy 41.)

611 Campbell Hill Street
Suite 102
Marietta, Georgia 30060
(770) 422-0642
(Behind Wellstar/Kennestone Hospital)

In the event a bone graft or soft tissue graft is performed to attempt to rebuild lost bone or improve tissue contour, I realize that several substances can be used. These include, but are not limited to my own bone or gum, a transplant from another human, synthetic bone or soft tissue substitutes, or processed bone or tissue from animals. These may be used alone, in any given combination, or with the addition of antibiotics. The use of bone grafts may require me to take antibiotics and/or other medicaments to attempt to improve the clinical result(s).

I understand that the material risks generally recognized and associated with this procedure(s) are infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis, paraplegia, quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death. I also understand that additional risks of the procedure and anesthesia include, but are not limited to:

a) post-operative pain and swelling that may necessitate several days of recuperation at home.
b) limited mouth opening, lasting days to weeks or longer.
c) delayed healing of tooth sockets (dry sockets) which may require additional post-operative care.
d) retention in my jaws or surrounding structures small fragments of tooth roots.
e) damage to other teeth, fillings, crowns, and dental appliances, which may require additional dental treatment.
f) opening into the sinus (the normal hollow cavity in the upper jaw) which may require additional post-operative treatment or surgery.
g) injury to nearby nerves which may result in tingling, reduced or abnormal sensation or taste or numbness in the chin, lips, teeth, gums, cheeks, palate or tongue. This abnormal feeling may be temporary, lasting several weeks or months, or rarely may be permanent.
h) fracture (breaking) of the jawbone(s), which may require additional post-operative treatment or surgery.
i) disturbance of the Temporomandibular joint (TMJ, hinge joint of the jaw).
j) prolonged unconsciousness, recovery, drowsiness, agitation or amnesia (loss or memory).
k) gum recession (shrinkage), interference with phonetics (speech sounds), sensitivity to hot or cold for days, weeks, or, on occasion, months, transient or, in some instances, permanent food lodging between the teeth, or exposure of crown (cap) margins or root surfaces.

I further understand that if no treatment, or limited non-surgical treatment is rendered, my present periodontal condition will probably worsen in time, which may ultimately result in tooth loss.

NO GUARANTEE, WARRANTY OR ASSURANCE HAS BEEN GIVEN TO ME THAT THE PROPOSED TREATMENT WILL BE SUCCESSFUL TO MY COMPLETE SATISFACTION. DUE TO INDIVIDUAL PATIENT DIFFERENCES, THERE EXISTS A SMALL RISK OF FAILURE OR RELAPSE, REQUIRING ADDITIONAL OPERATION(S), OR WORSENING OF MY PRESENT CONDITION DESPITE THE BEST OF CARE. HOWEVER, I HAVE BEEN INFORMED THAT IT IS THE DOCTOR'S OPINION THAT THE PROPOSED OPERATION(S) WILL BE HELPFUL, AND THAT ANY FURTHER LOSS OF SUPPORTING TISSUES OR BONE WOULD OCCUR SOONER WITHOUT THIS PROPOSED TREATMENT.

I understand that healing after periodontal surgery has been shown to be impaired by smoking, alcohol, high stress and poor nutrition. I agree to limit these adverse factors as much as possible and to follow the Doctor's post-operative and home care instructions. I understand that long-term success of periodontal therapy requires my long-term continued performance of effective personal plaque control (daily home care) and my receiving periodic supportive periodontal therapy ("dental cleanings"). The most common recall interval is every 2-4 months for cleanings and evaluations.

I consent to the taking of photographs, slides, videotapes and/or radiographs of my oral and facial structures for the purposes of diagnosis, comparison, and publication for educational or scientific purposes. I understand that I will not be identified in or by these presentations.

Signed _____ Date _____

(Patient, Parent or Guardian)

Witness _____ Doctor _____