Menlo Park Dental Excellence-ChauLong T Nguyen Dental Corporation
Dr. ChauLong Nguyen, DDS, MAGD, LLSR, AFAAID

905 Middlefield Rd, STE B, Palo Alto, CA 94301
Office #: (650) 838-0260 Email: chaulongdds@protonmail.com

Discussion and Informed Consent for Connective Tissue Graft & Gingival (Gum) Graft + Crown Lengthening

Patient Name: _____**Date**:_____

Diagnosis:
1. Gingival recession class 1, 2, 3, 4 for tooth # _____
2. Inadequate biologic width and or bone loss in tooth # _____

Treatment:
1. Connective Tissue Graft or Free Gingival Graft for tooth # _____
2. Crown lengthening for tooth # _____

FACTS FOR CONSIDERATION - *Patient's Initials Required*

_____I have been informed that I have a mucogingival (gums) problem around some of my teeth. This may mean I have insufficient attached gum tissue or a muscle attachment that could potentially cause the premature loss of teeth.

_____I understand that where there is insufficient attached gingiva (gum), bacteria and food can become lodged under the gumline and this may result in further recession of the gum or localized infection (gum abscess). I also understand that where there are fillings at the gumline or crowns (caps) with edges under the gumline, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or crowns or the material from which they are made do not cause significant irritation to the gum. I have been advised and understand that gingival graft surgery can help this problem.

_____It has been explained to me that this is a surgical procedure involving the removal of a thin strip of gum from somewhere in my mouth (usually the hard palate) or from commercial human or animal sources, and transplant near the area of gum recession. There, it can be placed at the base of the remaining gum or it can be placed to partially cover 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.

_____After anesthetics by injection have numbed the area to be operated, the gums are reflected (incised) to expose the teeth, the roots of the teeth are then cleaned and smoothed, antibiotics and/or other chemicals may be applied to the roots to decontaminate them before the graft material is placed in the area(s).

Benefits of Gingival Graft, Not Limited to the Following:

Gingival grafting may help in restoring an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. This procedure may also cover exposed

root surfaces, enhancing the appearance of the teeth and gum line, and treating and minimizing root sensitivity or decay.

Risks of Gingival Graft, Not Limited to the Following - *Patient's initials required*

_____I understand with surgery that there may be postoperative bleeding, swelling, pain, infection, facial discoloration, temporary or, on occasion, permanent tooth sensitivity to hot, cold, sweets, or acidic foods. A temporary or permanent numbing of the surgical areas, including the gums, lips and chin, may occur.

_____I understand that a small number of patients do not respond successfully to gingival grafting. If a transplant is placed to partially cover the tooth root surface exposed by recession, the gum placed over the root may shrink back during the healing. In such a case, the attempt to cover the exposed root surface may not be completely successful resulting in more recession or increased spacing between the teeth. The graft may appear different in color and thickness from the adjacent soft tissue.

_____I understand that I will receive a local anesthetic by injection and/or other medication(s). In rare instances, patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. ***Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury resulting in loss of feeling of the chin, lips, gums, tongue and loss of taste can result from an injection.***

_____I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____I understand that all medications have the potential for side effects, unintended reactions and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking, which are:

_____

_____

_____I understand that smoking and/or chewing tobacco and/or alcohol intake may affect gum healing and may limit or prevent the successful outcome of my surgery. Smoking may adversely affect the extraction site healing and may cause "dry socket" (an infection of the bone of the socket walls). Smokers are at higher risk for "dry socket" and have more dry sockets than non-smokers. I agree to follow instructions related to my own daily care of my mouth.

_____I also understand that:

1. The results of root coverage vary and are rarely 100%

2. The results of crown lengthening and pocket reduction may cause teeth to look longer, root exposure and new crowns are required after surgery.

3. Multiple procedures may be done to build back more tissue. This is at the discretion of each person and is based on his/her personal goals. If multiple procedures are undertaken, there will be additional surgical fees.

Alternatives to Suggested Treatment

_____I understand that alternatives to gingival grafting may include: (1) no treatment, with the expectation of chronic inflammation 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; (2) 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; (3) non surgical scraping of tooth roots and lining of the gum (root planing 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; (4) extraction of teeth involved with recession and a lack of attached gum tissue (which may need replacement with bridges, crowns or dental implants).

Alternatives discussed: #1, 2, 3, or 4 _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Check only one of the boxes below that applies to you:

☐ **Yes**, I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

OR

☐ **No**, I refuse to give my consent for the proposed treatment as described above and understand the potential consequences associated with this refusal.

_____ _____

Patient's (Patient Representative) Signature **Date**

I attest that I have discussed the risks, benefits, consequences, and alternatives to bone and gingival grafting with Mr., Mrs., Ms., _____ who has had the opportunity to ask questions, and I believe my patient understands what has been explained and willingly consents to the treatments noted herein. As part of this consent agreement, I give my personal pledge as a healthcare professional dedicated to the well-being of my patient to make every reasonable effort to assure the patient receives the best possible care with the least possible risk.

Dr. ChauLong Nguyen, DDS, MAGD _____Date:_____

Witness (Staff) Signature _____Date:_____