Menlo Park Dental Excellence-ChauLong T Nguyen Dental Corporation
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Discussion and Informed Consent for LASER Gingivectomy/Gingivoplasty, Crown Lengthening Treatment

Patient Name: _____**Date**:_____

Diagnosis: _____

Treatment: _____

FACTS FOR CONSIDERATION - *Patient's Initials Required*

_____ An examination of your oral cavity measures the pockets under the gums surrounding your teeth to determine which periodontal treatment(s) your gum condition requires. Dental x-rays will be taken to check the condition of the bone that supports your teeth.

_____ One type of surgical treatment, called a *gingivectomy*, is the surgical removal of diseased gingiva (gum tissue) to reduce or eliminate periodontal pockets that have failed to respond to more conservative treatment such as scaling and curettage. It includes deep scaling and planning of the root surfaces exposed during the surgery. Sedation or premedication may be recommended and prescribed for you prior to the surgery.

_____ We use LASER at the base of sulcus - No cutting or lifting gum.

_____ Treatment may also include *flap surgery* which involves cutting and lifting up a small area of the gums to expose the bony defect around the tooth. The affected tissue may be cleaned out, the bone recontoured (reshaped), and/or real or synthetic bone material may be grafted into the site. A barrier membrane may also be inserted and sutured into place, and a periodontal dressing (special band aide) may be placed over the area of surgery.

_____ Crown lengthening to obtain adequate supracrestal space for gum to heal properly after making a new crown in a tooth that has damage to the bone. This will make the tooth longer and adjacent teeth longer and sensitive due to the reduction of the bone and gum after gum-crown lengthening surgery.

_____ A gingival (gum) graft involves moving gum tissue from one site to another. Typically, this is done to cover an exposed root, or to provide a zone of attached gingiva around the tooth where the normal tissue has receded.

_____ The success of the treatment depends in part on your efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow proper home care taught to you by this office.
_____ A topical or local anesthetic may be administered depending on the location and depth of the area to be treated.

Benefits of Surgical Periodontal Treatment, Not Limited to the Following:
_____ Surgical periodontal treatment can: help to create a cleaner environment in which your gums can heal; help to reduce the chances of further gum irritation or infection; make it easier for you to keep your teeth clean; improve your chance to retain teeth and their function; and decrease the cost of replacing teeth lost due to gum disease. This course of treatment may help to improve your condition and prevent this disease from spreading.

Risks of Surgical Periodontal Treatment, Not Limited to the Following:
_____ As a result of surgery, I understand that my gums may bleed or swell and I may experience moderate discomfort for several hours after the anesthesia wears off and there may be slight soreness for a few days, which may be treated with pain medication. I will notify the office if conditions persist beyond a few days.
_____ I understand that because cleanings and surgery involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which may be treated with antibiotics. I will immediately contact the office if I experience fever, chills, sweats or numbness.
_____ 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 my gum tissue heals after treatment or surgery, it may shrink somewhat, exposing some of the root surface. This could make teeth at the gumline, which could trap food particles and require special maintenance. I understand additional surgical procedures are available to protect the sensitive areas.
_____ I understand that depending on my current dental condition, existing medical problems, or medications I may be taking, these methods alone may not completely reverse the effects of gum disease or prevent further problems. Teeth that become loose as a result of periodontal disease may be extracted, which may require replacing the teeth with a fixed or removable bridge, dentures, or artificial teeth called *implants*.
_____ I understand that unforeseen conditions may call for modification or change from the anticipated treatment or surgical plan. These may include, but are not limited to, (1) extraction of hopeless teeth, (2) the removal of hopeless tooth root of a multi-rooted tooth so to preserve the rest of the same tooth, or (3) termination prior to completion of all of the surgery originally outlined.

_____ I understand that smoking can adversely affect the outcome of periodontal therapy suggested and that final results achieved by periodontal therapy can be lessened or can cause the outright failure of the treatment by the fact that I have had a recent history of smoking.

_____ I understand that at the start and during treatmentI may receive a topical or local anesthetic and/or other medication. In rare instances, patients may have a reaction to the anesthetic, which could require emergency medical attention. **Depending on the anesthesia and medication administered, I may need a designated driver to take me home**. In rare cases, temporary or permanent nerve injury, numbness of the lip, chin, gums, teeth, cheek and/or tongue, can result from an injection.

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

_____

_____ I understand that while every reasonable effort will be made to ensure that my condition is treated it is not possible to guarantee perfect results. By signing below, I acknowledge that I have received information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

Consequence if No Treatment is Administered, Not Limited to the Following:

_____ I understand that if no treatment was administered or ongoing treatment was interrupted or discontinued, my periodontal condition may continue and probably worsen. This could lead to further inflammation and infection of the gum tissues, tooth decay above and below the gumline, deterioration of bone surrounding the teeth and eventually the loss of teeth.

Alternatives to Surgical Periodontal Treatment, Not Limited to the Following:

_____ I understand that surgical methods may also be prescribed to help control my gum disease. I have discussed with my dentist the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

Alternatives discussed: _____

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:

- ❏ I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

OR

- ❏ I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

_____ _____

Patient's or Patient's Representative's Signature Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to LASER periodontal treatment with the patient who has had the opportunity to ask questions, and I believe my patient understands what has been explained and willingly consents to the treatment.

_____ _____

Dentist's Signature Date

_____ _____

Witness (Staff) Signature Date