CONSENT FOR FREE-GINGIVAL GRAFTING PROCEDURE

Patient's Name _____ _____
DATE

It is essential that the surgical patient understand why his/her surgical procedure has been recommended, how it is performed and the major risks and complications that can accompany the procedure.

PLEASE READ AND INITIAL EACH PARAGRAPH BELOW. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING OR SIGNING THIS FORM.

_____ **1.** I hereby authorize Drs. Tyko/Daniel/Tolin/Chu and staff to treat the condition described as **Deficiency of Gum Tissue around the implant/tooth.**

_____ **2.** I have been informed of possible alternative forms of treatment (if any), including: **Doing nothing but hygiene or donor skin grafting.**

_____ **3.** The surgical procedure planned to treat the above condition has been explained to me, and I understand the nature of the treatment to be Free-Gingival Graft for Implant(s) under _____ anesthesia.

_____ **4.** The reason it has been recommended (the diagnosis) is the gum overlying the area of my implant is deficient or too thin.

_____ **5.** How the procedure is performed: Sometimes the gum is too thin or deficient in the area of the implant(s) to provide healthy tissue around the implants. In such cases, firm, thick gum tissue from the palate can be grafted into the area of the implants. An incision is made through the gum on the palate and a piece taken to transplant to the area of the implants. The raw area created by removal of the palatal tissue is usually covered with a splint, which is a temporary plastic plate similar to an orthodontic retainer. The gum tissue from the palate is stitched in place in the area of the implants.

_____ a. In my case the graft will be taken from the palate

_____ b. The graft will be placed around the implant(s) in the tooth #_____ area.

_____ **6.** We have discussed the major risks, complications and side effects that may be associated with this procedure. These include

_____ a. A few days of swelling and discomfort, which may require that you stay at home before you resume your normal activities.

_____ b. Bleeding that can, at times, be heavy or prolonged and can occasionally require additional treatment.

_____ c. Infection may develop and result in loss of a portion or all of the graft. Management of the infection may require additional treatment.

_____ d. Injury to the nerves that provide the feeling to the tissues at the site where the graft was taken. This can result in a tingling sensation, numbness, pain or other sensations of the tissues of the palate. The sensations may persist for weeks, months and can occasionally be permanent.

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_____ e. The gum tissue graft may not "take" in the area to which it has been transferred and may need to be removed.

_____ f. A loss of the gum tissue in the site where the graft was taken (soft tissue "slough") can occasionally occur. In such cases, healing of the area may be prolonged and require maintenance of a soft diet for an extended period.

_____ g. Patients can sometimes develop allergic reactions to one of the medications or other materials used in their treatment.

_____ **7.** Sometimes during the course of treatment unforeseen conditions may occur that will require changes be made in the treatment described in paragraph 5 above. I authorize Drs. Chu/Daniel/Tyko and his/her staff to use their professional judgment to modify the treatment as necessary and perform any additional procedure that may be required.

_____ **8.** I understand the importance of providing accurate information about my health history, especially concerning possible pregnancy, allergies, use of medications and history of drug or alcohol use. If I misinform my doctor, I understand the consequences may be life-threatening or adversely affect the results of my surgery.

_____ **9.** I have been advised of my option for a second opinion from another doctor regarding the proposed treatment.

_____ **10.** I realize that, despite all precautions that may be taken to avoid complications, there can be no guarantee as to the result of the proposed treatment.

INFORMATION FOR FEMALE PATIENTS

_____ I have informed my doctor about my possible use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate mechanical forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT FOR FREE-GINGIVAL GRAFTING PROCEDURE *(CONTINUED)*

_____ **11.** I give my consent for this free-gingival grafting procedure, and am aware that no guarantee can be made as to the outcome.

PATIENT'S/LEGAL GUARDIAN'S SIGNATURE	DATE
DOCTOR'S SIGNATURE	DATE
WITNESS' SIGNATURE	DATE