Midtown Dental Services

CONSENT FOR CONNECTIVE TISSUE GRAFT

Diagnosis: After careful oral examination, my periodontist has advised me that I have significant gum recession and/or inadequate tissue quality. Exposed root surfaces are more susceptible to root decay. If not treated, further recession of the gum and/or eventual tooth loss may occur.

Recommended treatment: My periodontist has recommended gingival augmentation (grafting) surgery. Under local anesthetic, tissue will be taken from the palate (roof of the mouth) and placed so as to partially or completely cover the tooth root surface exposed by the recession.

Expected benefits: The purpose of gingival augmentation is to restore adequate attached gum tissue, improving the quality of the tissue and reducing the likelihood of further gum recession. Covering exposed root surfaces can help to prevent root sensitivity or root decay as well as enhance the esthetics of the area.

Alternative treatments: My periodontist has explained any possible alternative treatments for my gum recession. These may include no treatment, continued monitoring for progressive recession, and/or modification of home care techniques.

Risks and complications: I understand that complete root coverage may not be achieved. A second surgical procedure may be indicated if the initial surgery is not satisfactory. In some cases, increased recession and/or spacing between the teeth may result. I understand that complications from this procedure may include, but are not limited to, post-surgical infection, bleeding, swelling, facial discoloration, temporary numbness, and/or tooth sensitivity. I understand that proper post-operative care is important to the success of my graft.

Publication of records: I authorize the use of photos or radiographs and documentation of my treatment for educational purposes. My identity will not be revealed to the general public without my permission.

I have been fully informed of the nature of gingival augmentation surgery and have had the opportunity to ask any questions regarding my treatment. I understand all of the above and consent to the procedure as described above.

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Signature of patient (parent/guardian) Date

_____ _____

Witness Date