CONSENT FOR ESTHETIC CROWN EXPOSURE SURGERY

Diagnosis. After a careful oral examination, my periodontist has advised me that I have insufficient exposure of my tooth and/or overgrowth of gum tissue. This condition is primarily an esthetic problem, due to both an excessive exposure of gum tissue and teeth that appear to be too short.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include crown exposure surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment.

During this procedure, my gum will be reduced to expose the proper amount of tooth. Bone around the teeth may be reduced and reshaped to a proper level and my gum will then be sutured back around the teeth where required.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan.

Expected Benefits. The purpose of crown exposure surgery is to expose the proper length of tooth for improvement of the function of my teeth and to make my oral hygiene more effective.

Principal risks and Complications. Crown exposure surgery is limited by the length of both the crown and the root of each tooth. Because each patient's condition is unique, the final tooth length and remaining gum exposure will vary.

I understand that complications may result from the crown exposure surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, pain, swelling, facial discoloration, tooth sensitivity to hot, cold, sweet or acidic foods, and cracking or bruising of the corners of the mouth. Less common side effects include, but are not limited to, numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that occasionally there is a need for a second procedure if the initial results are not satisfactory. In addition, the success of crown exposure procedures can be affected by (1) inadequate oral hygiene (2) smoking (3) clenching and grinding of teeth (4) alcohol consumption (5) medical conditions, (6) dietary and nutritional problems and (7) medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence

in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives To Suggested Treatment. I understand that alternatives to crown exposure surgery include: no treatment.

Necessary Follow-up Care. I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. I further understand that long-term success requires my long-term continued performance of daily plaque removal and my return for periodic professional maintenance therapy.

No Warrant or Guarantee. I know the practice of dentistry is not an exact science and that reputable practitioners cannot guarantee results. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment would provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records. I authorize photo, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry or dental insurance documentation. My identity will not be revealed to the general public, however, without my permission.

I have been fully informed of the nature of periodontal surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self care. I have had any opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Patient or legal guardian: _____ Date: _____

Witness: _____ Date: _____