MARIANNE MORELLI, D.M.D.
BROOKFIELD FAMILY DENTISTRY, LLC

INFORMED CONSENT FOR GINGIVAL GRAFTING

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of significant gum recession or insufficient gum tissue in my mouth which may be adjacent to muscle attachment. I understand that it is important to have sufficient amount of firm gum tissue around teeth at the gumline to minimize further gum recession which may compromise tooth retention

EXPLANATION OF GINGIVAL GRAFTING: I have been informed that the main purpose of gingival (gum) grafting is to create an adequate zone or band (width) of firm gum tissue to help further prevent gum recession. Graft surgery may also be performed to cover exposed roots.

RECOMMENDED TREATMENT: It has been recommended that Gingival Grafting be performed in area(s) of my mouth where I have gum recession. I understand that some or all of the gum tissue may shrink back during healing and that the proposed surgical attempt to cover the exposed root surface may not be completely successful

INHERENT RISKS ASSOCIATED WITH TREATMENT: Although gingival grafting is a low risk procedure, risks related to gingival grafting might include but not limited to post-operative bleeding, swelling, pain, infection, facial discoloration, temporary or occasional tooth sensitivity to hot/cold/sweets/acidic foods. A temporary or permanent numbing of the surgical area(s) may occur on a rare occasion. Risks related to the local anesthetics include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the injection site(s).

ALTERNATIVE TREATMENT(S): I have the choice of not receiving any treatment to the area(s) involved. It has been explained to me that doing nothing leaves the tooth open to sensitivity, microbiological insult and eventual bone and/or tooth loss.

I understand that during surgery, unforeseen condition(s) may be discovered which may call for a change from the anticipated surgical plan. I therefore consent to the performance of necessary alternative/additional procedures as deemed necessary in the best judgment of the treating doctor. I acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in treating recessions. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the potential for longer retention of teeth by reducing the likelihood of further gum recession in the treated area(s) however success is not assured. Therefore, failure, relapse, selective retreatment, or worsening of my present condition may occur.

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CONTINUED INFORMED CONSENT
FOR GINGIVAL GRAFTING

I understand that smoking and/or alcohol intake may adversely affect gum healing and compromise surgical success. I agree to follow all pre and post-operative instructions provided. I voluntarily assume the risks, including the risk or substantial harm which may be associated with any part of this treatment. In view of the above information, I authorize the doctor and/or such associates and assistants as necessary to render any treatment necessary and/or advisable to my dental condition including any and all anesthetics and/or medications.

Patient Name (Printed)_____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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