

**WILLIAM E. MASON, D.D.S., M.S.
PERIODONTICS-DENTAL IMPLANTS**

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Informed Consent for Periodontal Surgery and/or Extractions and/or Dental Implants

Date: _____ Surgery: _____
BP: _____

Areas on this form which can be checked are marked as it applies to the treatments to be performed.

Diagnosis

After a careful oral examination, radiographic evaluation and study of my dental condition, Dr. Mason has advised me that I have periodontal disease. I understand that periodontal disease weakens the support of my teeth by separating the gum from my teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further loss or erosion of bone and gum supporting the roots of my teeth. If left untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences which may include systemic problems such as cardiovascular disease.

Periodontal Surgery

In order to treat this condition, Dr. Mason has recommended that my treatment include periodontal surgery. I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment. I further understand that antibiotics and other substances may be applied to the roots of my teeth.

___ Osseous Surgery: During this procedure, my gums will be opened to permit better access to the roots and bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped. My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

___ Crown Lengthening/Gingivectomy: During this procedure, my gums will be opened to permit better access to the roots and bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. In order to gain greater tooth length, some bone and/or gum will be removed around the tooth or teeth to be lengthened as well as the adjacent teeth and any bone irregularities may be reshaped.

My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

___ Bone Regenerative Surgeries: In order to treat my periodontal condition, Dr. Mason has recommended that my treatment include bone regenerative surgery. During this procedure, my gum will be opened to permit better access to the roots and to the eroded bone. Inflamed and infected gum tissue will be removed and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped. Graft material will be placed in the areas of bone loss around the teeth. Various types of graft materials may be used. These materials may include my own bone, synthetic bone substitutes, or bone obtained from tissue banks (allografts). Membranes may be used with or without graft material depending on the type of bone defect present. My gum tissue will be sutured back into position over the above materials and a periodontal bandage or dressing may be placed.

Gingival Augmentation Surgery:

___ Free Gingival Grafting: This surgical procedure involves the transplanting of a thin strip of gum from the palate or elsewhere in my mouth. The transplanted strip of gum can be placed at the base of the remaining gum or it can be placed so as to partially cover exposed root surface(s) exposed by recession. My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

___ Subepithelial Connective Tissue Grafting: This surgical procedure involves taking connective tissue obtained from the palate or using Alloderm (an acellular dermal matrix) and securing it over the root surface(s) exposed by recession and covering it with the remaining gum. My gum will then be sutured into position and a periodontal bandage or dressing may be placed.

Dental Implants:

___ Root Form Dental Implants: Gum tissue will be opened to expose the bone. Implants will be placed by threading them into holes that have been drilled into my jaw bone. The implants will have to be snugly fitted and held tightly in place during the healing phase. Soft tissue will be stitched over, closed over or around the implant(s). Healing will be allowed to proceed for a period of four to six months. I understand that dentures cannot be worn during the first one to two weeks of the healing phase.

I further understand that if during the surgery, clinical conditions turn out to be unfavorable for the use of this implant system or prevent the placement of implants, my periodontist will make a professional judgment on the management of the situation. The procedure may need to be canceled or may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw to allow placement, gum closure,

and security of my implants.

For implants requiring a second surgical procedure, the overlying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implant. Plans and procedures to create an implant prosthetic appliance or artificial crown can begin.

Prosthetic Phase of Procedure – I understand at this point that I will be referred back to my general dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthetic device will be attached to the implant. This procedure should be performed by a person trained in the prosthetic protocol for the root form implant system.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to: (1) Extraction of hopeless teeth to enhance healing of adjacent teeth, (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or (3) termination of the procedure prior to completion of all of the surgery originally outlined.

___Recommended Extractions:

In order to treat this condition, Dr. Mason has recommended that my treatment include extraction(s) of my tooth (teeth). I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment.

Expected Benefits of Periodontal Treatment:

The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

___Osseous Surgery: The purpose of osseous surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth.

___Crown Lengthening/Gingivectomy: The purpose of the crown lengthening procedure is to provide the general dentist or prosthodontist more access as well as more tooth structure to work with when the tooth is repaired. It will also help create a biologic width, which will reduce postoperative inflammation.

___Bone Regenerative Surgeries: The purpose of bone regenerative surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The

surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable professionals to better clean my teeth. The use of bone, bone grafting material, or the placement of a membrane is intended to enhance bone and gum healing.

___Gingival Augmentation/Frenectomy Surgery: Free Gingival Grafting & Subepithelial Connective Tissue Grafting- The purpose of gingival augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of teeth and gum line, or to prevent or treat root sensitivity or root decay.

___Root Form Dental Implants: The purpose of dental implants is to allow me to have a more functional artificial teeth or improved appearance. The implants provide support, anchorage, and retention for artificial teeth or crowns.

Expected Benefits of Extractions:

The purpose of the extraction(s) is to remove a tooth (or teeth) which in the present condition will probably worsen with time, and the risks to my health may include, but are not limited to, the following: pain, swelling, infection, cyst formation, periodontal gum disease, dental decay and malocclusion.

Principal Risks and Complications:

I understand that a small number of patients do not respond successfully to periodontal surgery, and in such cases, the involved teeth may be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition and oral hygiene is unique, long-term success may not occur.

___Osseous Surgery: I understand that some patients do not respond successfully to the osseous surgery procedure. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases, the involved teeth may ultimately be lost. Teeth will appear longer following this procedure. Sensitivity is sometimes associated with this procedure and may or may not be reduced over time.

___Crown Lengthening/Gingivectomy: I understand that some patients do not respond successfully to crown lengthening procedures. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases, the involved teeth may ultimately be lost. Transient, but on occasion permanent, increased tooth looseness may occur. If during the surgery Dr. Mason finds a fracture or any other finding that would compromise my tooth (teeth), the crown lengthening procedure will be stopped and the tooth would be extracted at or after the time of surgery.

___Bone Regenerative Surgeries: I understand that some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. In rare cases, the involved teeth may ultimately be lost.

___Gingival Augmentation/Frenectomy Surgery: Free Gingival Grafting & Subepithelial Connective Tissue Grafting – I understand that a small number of patients do not respond successfully to gingival augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession or with increased spacing between the teeth.

___Root Form Dental Implants: I understand that some patients do not respond successfully to dental implants, and in such cases, the implant may need to be removed. Implant surgery may not be successful in providing artificial teeth. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the periodontal surgery and tooth extraction, drugs, or local anesthetics. The exact duration of any complications cannot be determined and they may be irreversible. These complications include but are not limited to:

Pain

Postoperative discomfort and swelling that may necessitate several days of home recuperation.

Heavy bleeding that may be prolonged

Shrinkage of the gum upon healing, resulting in elongation of some teeth and greater spaces between some teeth

Tooth sensitivity to hot, cold, sweet or acidic foods

Transient, but on occasion permanent, increased tooth looseness

Stretching of the corners of the mouth, with resultant cracking or bruising

Restricted ability to open the mouth for several days or weeks

Facial discoloration (i.e. bruising)

Post-surgical infection requiring additional treatment

Injury to adjacent tissue, teeth, caps, fillings, or other dental work

Dry socket or onset of increased pain several days after a tooth extraction

Painful bone particles that may need to be removed

Decision to leave a small piece of root in the jaw when its removal would require extensive surgery

Opening of the sinus (a normal cavity situated above the upper teeth), requiring additional surgery

Injury to the nerve underlying the teeth, resulting in transient numbness or tingling, but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum

Breakage of the jaw

Jaw joint injuries or associated muscle spasm

Impact on speech

Allergic reactions

Accidental swallowing of foreign material

The need for possible additional procedures/surgeries

The need for possible future orthodontic treatment

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to Dr. Mason any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that I have. I understand that my diligence in providing the personal daily care recommended by Dr. Mason and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment:

I understand that alternatives to periodontal surgery include:

- (1) No treatment – with the expectation of possible advancement of my disease which may result in premature loss of teeth.

- (2) Extraction of teeth involved with periodontal disease
- (3) Non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with or without medication, in an attempt to further reduce bacteria and tartar under the gum line, with the expectation that this will not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care, time and commitment, and may result in the worsening of my condition and the premature loss of teeth.

Necessary Follow-up Care and Self-Care:

I understand that it is important for me to continue to see my regular general dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, Dr. Mason may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth, the extraction of one or more teeth, the performance of root canal therapy, or the orthodontic movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

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 Dr. Mason can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by Dr. Mason and (2) to see Dr. Mason regularly and my general dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances by the general dentist or prosthodontist.

No Warranty or Guarantee

I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help 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 care.

Publication of Records:

I authorize photos, 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. My identity

will not be revealed to the general public.

I have been fully informed of the surgery to be performed. Dr. Mason has explained that evidence indicates the procedure is needed to maintain a healthy periodontal condition. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self care. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

I consent to the administration of local anesthetic.

I realize that during the course of the surgery, the treatment may need to be modified due to existing conditions that are only evident when the surgical site has been exposed.

Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol, or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs or until fully recovered from the effects of the same.

I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Mason. I hereby consent to the performance of periodontal surgery and/or extraction(s) as presented to me and consent to any additional or alternative procedures that may be deemed necessary in the judgment of Dr. Mason. I agree to be ultimately responsible for payment of the periodontal treatment(s) and/or extraction(s) in full.

By signing below, I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the operation and the explanation referred to or made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed. I also state that I read and write English.

By signing below, I certify that I have read, fully understand, and agree to this document:

Date

Patient, Parent, or Guardian signature

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