Paul D'Aoust Dentistry Professional Corporation
732 Arlington Park Place
Kingston ON K7M8H9

(613)634-6221

www.kingstonperio.com

CONSENT FOR ORAL SURGERY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Diagnosis: Periodontal Flap Surgery
After a careful oral examination, Dr. D'Aoust has advised me that I have periodontal disease. I understand that periodontal disease weakens the support of my teeth by separating the gum from the teeth and destroys 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 of supporting bone and gum. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my general health.

Recommended Treatment:
In order to treat my condition, Dr. D'Aoust has recommended that my treatment include periodontal surgery. I understand that a local anesthetic will be administered to me as part of the treatment and sedation may be utilized. During the procedure, my gum tissue will be reflected to permit better access to the roots of my teeth and the underlying bone. Inflamed gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped, and bone regenerative material may be placed around my teeth. My gum will then be stitched back into position and a periodontal bandage or dressing may be placed.
I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan.

Expected Benefits:
The purpose of periodontal surgery is to access the roots of teeth for optimum cleaning, to reduce infection and inflammation, to decrease pocket depths for ease of maintenance by me and my dental professionals in the future, and to regenerate lost periodontal structures where possible.

Alternatives to Suggested Treatment:
I understand that alternatives to periodontal surgery include:

--No treatment, with the expectation of possible advancement of my periodontal condition which may result in premature loss of teeth.
--Extraction of teeth involved with periodontal disease.
--Non-surgical cleaning of the root surfaces (scaling and root planing), with or without medication, in an attempt to reduce the bacteria and tartar under the gum line, with the expectation that this may not fully eliminate the bacteria in deep pockets, will require more frequent professional care and time commitment, may not arrest the worsening of my periodontal condition, and may lead to the premature loss of teeth.
--Application of local or systemic antibiotics or disinfectants in an attempt to reduce bacteria and inflammation under the gum line.

In addition to the expectations listed above, these medicaments may need frequent regular reapplication since deposits below the gum line may be masked rather than eliminated.

Primary Risks and Complications:
I understand that a small number of patients do not respond successfully to surgery, and in such cases, the involved teeth may eventually be lost. Because each patients condition is unique, long-term success may not occur.I understand that complications may result from the surgery, drugs, and anesthetics. These complications include, but are not limited to:
- Bleeding, swelling and pain
- Allergic reactions
- Post-sugical infections
- Impact on speech
- Facial discolouration (bruise)

Paul D'Aoust Dentistry Professional Corporation
732 Arlington Park Place
Kingston ON K7M8H9

(613)634-6221

www.kingstonperio.com

- Accidental swallowing of foreign objects
- Transient or permanent numbmess of the lip, tongue, teeth, chin or gum
- Transient or premanent tooth sensitivity to hot, cold, sweet or acidic foods
- Delayed healing
- Jaw joint injuries or muscle spasms
- Cracking or bruising of the corners of the mouth; breakout of cold sores
- Restricted ability to open mouth for several days or weeks
- Worsening of the condition
- Transient or permanent tooth looseness
- Fracture of adjasent restorations or teeth
- Exposure of crown margins on teeth with crowns/bridges/veneers

I understand that if I smoke, I have more risk for the above complications. The exact duration of any complication(s) 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 there may be a need for a second procedure if the initial 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 my surgeon any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which may in any way relate to this surgical procedure.

No Warranty or Guarantee:
I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a therapist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth or implants, despite the best care.

Sedation:
I understand that if I take oral or IV sedation, I will need a driver to and from my appointment and that I should not operate any heavy equipment/machinery for 24 hours following the use of sedation.

PATIENT CONSENT:
I have been fully informed of the nature of the required extraction or oral surgery, the risks and benefits, the alternative treatments available, and the necessity for follow-up care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my surgeon. After thorough deliberation, I hereby consent to the performance of extraction or oral surgery as presented to me during consultation and in the treatment plan presented to me. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my surgeon. I understand that these additional or alternative procedures may involve added cost that may not have been outlined in the estimate of treatment costs.

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

Signature: _____ Date: _____

Response Date: _____