



**GINGIVECTOMY  
AUTHORIZATION AND CONSENT TO PERIODONTAL SURGERY**

I hereby authorize the doctor to perform the following procedure(s):

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It has been explained to me that I have periodontal (gum) disease or other gum problems and that I require the following procedure(s): the use of local anesthetics (freezing), reflecting the gums enough so that the roots of the teeth and surrounding tissue can be thoroughly cleaned of infecting agents, smoothing and reshaping the adjacent bone to its normal shape, grafts of synthetic and/or sterilized human or animal donor bone, use of sutures (stitches), use of a dressing or covering of the site.

I also have been informed that an alternate procedure which, though not the recommended therapy, may also benefit me to some extent is: thorough cleaning of the root surfaces (scaling and root planning) using local anesthetics (freezing), but without gaining access b reflecting the gums.

I understand that risks of the recommended treatment include, but are not necessarily limited to: (a) allergic or other reactions to the local anesthetic or other medication used, (b) swelling and/or infection, (c) pain and/or thermal sensitivity, (d) exposure of root surfaces (gum recession) and/or margins of crowns (caps), (e) increased tooth mobility, (f) temporary restricted mouth opening, (g) numbness of jaw or gum nerves.

I understand if no treatment is rendered the risks to my dental health include, but are not limited to: (a) further deepening of periodontal (gum) pockets, (b) halitosis (bad breath), (c) gum abscesses (boils), (d) loosening or drifting (movement) or teeth, (e) uncontrolled gum recession, (f) premature loss of teeth.

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth. However, it is Dr. Fatemi's opinion that therapy will be helpful and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.

It has also been explained to me that in order for me to achieve long term benefits from my treatment, it is required that I perform effective daily oral hygiene (plaque control procedures) and regularly attend for cleanings (maintenance care).

I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SATISFACTORILY SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT BEFORE HEREBY SIGNING.

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*Patient or authorized person to sign for patient*                      *Date*                      *Patients name*

If not the patient, what is your relationship to patient? \_\_\_\_\_

I have explained the condition, procedures, benefits, alternatives, and risks described on this form to the patient or representative.

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*Dr. Fatemi's signature*                      *Date*