INFORMED CONSENT FOR PERIODONTAL SURGERY

A. IDENTIFICATION

I, _____ willingly agree to the following procedure:
(Print your full name)

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. Such complications may involve, but are not inclusive to:

- Infection, bleeding, numbness, tissue tenderness, teeth sensitivity, changes in tissue appearance, loss of tissue height, exposed roots, perforation of the tooth root, loss of teeth, damage to adjacent structures, jaw or joint soreness (TMD), damage to existing restorations and changes in fit of partials or dentures.

I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be:

- The recontouring of my gums and bones in order to stabilize my periodontal disease and/or to create a biocompatible and/or esthetic environment in preparation for future restorations or procedures.
- The removal and smoothing of bone (including tori and tuberosities) as deemed necessary by the doctor for improved healing and a better prosthetic result.
- I understand that if possible, bone or tissue grafts may be used in order to facilitate the above mentioned results. I have been informed of the possibility that donated bone from cadavers may be used as well as synthetic or my own gum and bone tissue.
- The teeth that these procedures will be performed on are located in the area of:
  Upper / Lower *(Circle appropriate one(s))*
  Front / Back *(Circle appropriate one(s))*
  Left / Center / Right *(Circle appropriate one(s))*

This procedure will be performed under the direction of **Dr.**_____**.**

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the above-named dental facility, during the course of the above-named operation or procedure.

C. SIGNATURES

1. COUNSELING DENTIST/PROFESSIONAL: I have counseled this patient as to the nature of the proposed procedure(s), attendant risk involved, and expected results, as described above.

Signature of Counseling Dentist/Professional	**Date and Time**

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, described above.

Signature of Patient or Legal Guardian	**Date and Time**
Signature of Witness	**Date and Time**