

Dental Practice of
Robin H. Berrin, DDS
Robert W. Pretel, DDS, MSD
P. Paul Towfighi, DDS, MS
P. Kevin Chen, DMD, MS



Rosemary Wu, DMD, MS
Nidhi Jain, BDS, DMD, MS
Aneel Nath, DDS
Khalid Rasheed, DDS

Patient Consent for Periodontal Treatment

Patient Name: _____ **Date:** _____

I hereby authorize Dr. Berrin Pretel Towfighi Chen Wu Jain Nath Rasheed, and whomever the doctor may designate as the assistant to perform the following necessary therapeutic periodontal procedures:

LAPT/LAIP UR UL LR LL
 Periodontal Flap Surgery UR UL LR LL Crown Lengthening Teeth # _____

The purpose of these procedures is to allow access for removal of bacteria by cleaning the roots of teeth and the lining of the gums to allow for pocket reduction, infection, inflammation (swelling). The reduction in gum pocket depths may improve the ease and effectiveness of personal oral hygiene and of professional cleanings. The decrease in infection and inflammation may minimize further loss of bone and gum tissue supporting teeth, which may aid in longer retention of teeth in the operated area(s). An overall bite adjustment with grinding and shaping of my teeth, fillings and crowns may be a necessity. I understand adjusting crowns can remove porcelain, expose metal and/or tooth structure, and can require the replacement of any and all crowns. This procedure is also sometimes performed to expose more tooth structure to receive new restoration.

Tissue Regeneration & Bone grafting

The purpose of this procedure, in conjunction with periodontal surgery, is to treat irregularities to the jaw bone by the use of bone grafting materials for the reduction of pockets, infection and inflammation; improve bone healing; and aid in the longer retention of teeth in the operated area(s). The materials used in this procedure are human, bovine, porcine and synthetic tissues. All donors are screened by physicians and other health care professionals to prevent transmission of disease. Donors are tested for hepatitis, syphilis, blood and tissue infection and for exposure to the AIDS virus. Tissue is recovered and processed under sterile conditions. Bovine (cow) and porcine (pig) derived grafts also undergo similar processing.

Extraction(s) – Teeth #(s) _____

Frenectomy: Area _____ Biopsy: Area _____ Gingivectomy UR UL LR LL

Gingival (gum tissue) Grafting – Teeth #(s) _____

The purpose of this procedure is to create an adequate zone or band (width) of firm gum tissue to help prevent further gum recession and/or to potentially cover exposed root(s). Gingival grafting will be performed in the areas of gum recession. The surgical procedure involves: removing a thin strip of tissue from the surface, or beneath the surface of my mouth alongside the upper teeth, and/or utilizing donor dermal tissue from a tissue bank, and transplanted (moved) to the area of gum recession or exposed root(s). I understand that some or all of the tissue placed over the root(s) may shrink back during healing and purposed surgical attempt to cover the exposed root(s) may not be completely successful.

Alternative Treatments:

1. No treatment with potential worsening of my condition resulting in loss of teeth
2. Extraction of teeth involved with advanced bone loss
3. Non-surgical scraping of tooth roots (root planing), which may not fully eliminate deep bacteria and tartar, but instead result in partial and temporary reduction of swelling and infection. This may not completely reduce gum pockets and I may require more frequent professional care, or result in worsening of my condition and premature tooth loss.

Risk Related to The Suggested Treatment:

The risk of surgery might include, but is not limited to: post surgical infection; bleeding; swelling; pain; facial discoloration; transient, but on occasion, permanent numbness of the lip, tongue, teeth, chin or gum; jaw joint injuries or associated muscle spasm; transient, but on occasion permanent, tooth looseness; tooth sensitivity to hot, cold or sweet or acid foods; and shrinkage of the gum upon healing resulting in the elongation of some teeth, interference with phonetics (speech sound), exposure of margins of existing crown restorations and greater space between some teeth. Risk related to anesthetic might include, but is not limited to: allergic reactions; accidental swallowing of a foreign matter; facial swelling, bruising and/or pain; soreness and/or discoloration of the injection site.

No Warranty or Guarantee:

I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in decreasing pocket depths, infections, further bone loss or gum recession. It is anticipated (hoped) that the surgery or laser surgery will provide benefit in reducing the cause of this condition and produce healing to increase the potential for longer retention of teeth. Due to individual patient differences, certainty of success is not assured; therefore, risk of failure, relapse, selective retreatment, or worsening of the present condition, including the loss of certain teeth, can occur with progressive involvement despite the best of care.

Consent to Unforeseen Conditions:

During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include, but are not limited to: the extraction of hopeless teeth to improve healing of adjacent teeth; the removal of a hopeless root of a multi-rooted tooth, so as to preserve the tooth; the placement of bone graft material or the use of material to guide (enhance) tissue regeneration; or the termination of the procedure prior to the completion of all surgery originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Compliance with Self-Care Instructions:

I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I also agree to report for appointments following my surgery so that my healing can be monitored and my doctor can evaluate and report on the outcome of the treatment upon completion of healing.

Oral/IV/Anti-Resorption Medications (i.e. Fosamax, Boniva, Denosumab):

Due to your history of currently (or previously) being treated with these drugs, there is a small, but real risk of medication-induced osteonecrosis of the jaw (MRONJ) associated with dental treatment. Anti-resorptive medications appear to adversely affect the vitality and health of jawbones, thereby reducing or eliminating the jawbone’s ordinary, excellent healing capacity. Spontaneous exposure of the jawbone (osteonecrosis) may result. This is a long-term, destructive process in the jawbone that is often difficult or impossible to eliminate.

The overall risk is currently estimated to be between .01-1.15% and appears to be dependent upon the dosage and duration of anti-resorption therapy plus the occurrence of an oral surgery or trauma event. The decision to continue or discontinue oral /IV/anti-resorption medications before or during dental treatment should be made by you in consultation with your medical doctor.

If a complication occurs, short or long-term antibiotic therapy may be used to help control the infection. Despite all precautions, there may be delayed healing; osteonecrosis; loss of bone and soft tissues; pathologic fracture of the jaw; oral cutaneous fistula (open draining wound); or other significant complications. If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, long-term antibiotics and debridement to remove nonvital bone. Reconstructive surgery may be required.

Even if there are no immediate complications from the proposed dental treatment, the area is always subject to spontaneous breakdown and infection due to the condition of the bone. Minimal trauma from a toothbrush, chewing hard foods, or denture sores may trigger a complication, therefore long-term post-operative monitoring may be required.

Supplemental Records and Their Use:

I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications, provided my identity is not revealed.

Patient Endorsement:

My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document, as well as the explanations referred to or implied. After careful consideration, I give my consent for all procedures indicated above, which were presented to me during my consultation and treatment planning, or as described in the document. If I am sedated I agree not to operate a motor vehicle or hazardous device for at least 24 hours or until fully recovered from the effects of the sedation medication given.

_____ Signature of Patient (Parent or Legal Guardian)	_____ Date	_____ Signature of Witness	_____ Date
<i>Sacramento Office</i> 1810 Professional Drive, Suite B Sacramento, California 95825 (916) 971-3461 (916) 973-9830 Fax SacramentoAdmin@Capperio.com	<i>Laguna Office</i> 9309 Office Park Circle, Suite 110 Elk Grove, California 95758 (916) 684-3379 (916) 684-4106 Fax LagunaAdmin@Capperio.com	<i>Roseville Office</i> 2428 Professional Drive, Suite 100 Roseville, California 95661 (916) 786-6585 (916) 786-7542 Fax RosevilleAdmin@Capperio.com	<i>Folsom Office</i> 2535 East Bidwell, Suite 150 Folsom, California 95630 (916) 984-1109 (916) 984-1764 Fax FolsomAdmin@Capperio.com