

CONSENT TO PERIODONTAL SURGERY

I _____(name) hereby authorize Dr. Bouffard to administer the necessary anesthesia and perform the following surgical treatments as indicated below. A description of the planned procedure has been verbally made to me.

Surgical Treatment Planned: _____

I understand that I have a periodontal condition which has resulted in damage to the soft tissue or bone around my teeth, and which is compromising the health of my oral tissue. My condition, if left untreated will not generally improve, and may continue to deteriorate, leading to further damage or loss of my teeth.

I also understand that a variety of surgical procedures are used to treat periodontal conditions, all of which have a high degree of success. However, individual success cannot be guaranteed, and no guarantee or assurance has been given me. A risk of relapse, failure or worsening of my condition exists.

It has been explained to me that the long term success of my treatment requires my cooperation and performance of effective plaque control on a daily basis, and strict adherence to my plan of treatment, including periodic maintenance visits after the proposed surgical treatment is performed. Periodontal disease is chronic in nature, and requires continuous treatment to maintain stability. Periodontal disease is not currently curable, but usually controllable.

My periodontal condition may worsen over time without effective treatment, which may result in painful episodes, and/or premature tooth loss, or it may spontaneously stabilize without treatment. Alternative modes of therapy including: no treatment, non-surgical therapy, other surgical treatments, or extraction have been explained to my level of understanding.

Complications to periodontal surgery are rare, but do occur. They include, but are not limited to; pain, infection, bleeding, swelling, nerve trauma, loose teeth, food impaction, and post-operative sensitivity to hot and cold. Other potential risks include reactions to medicines including local anesthetics, graft materials and post-operative pain medicines. Reactions range from nausea and vomiting to allergic/anaphylactic reactions which can lead to rash, shock, or even death.

I understand that Dr. Bouffard may discover other or different conditions which may require additional or different procedures than those planned. I authorize him to perform such other procedures, which are advisable in his professional judgement. I consent to photography of my oral tissues for use in educational presentations or publications with the stipulation that my identity not be revealed.

I certify that I have read and fully understand the above, and consent to the surgical treatment planned. I have been given the opportunity to ask any questions or request a more detailed explanation, and to discuss with the doctor my past medical history as it may impact the treatment planned:

Date: _____ **Patient's Signature:** _____

Date: _____ **Surgeon:** _____ **Witness:** _____