CONSENT FOR TOOTH UNCOVERING

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have an impacted tooth. The tooth is in a position whereby it cannot or only very slowly enter the oral cavity in alignment with the adjacent dentition. Sometimes this tooth is partially visible through the gum tissue; however, more often it is covered by gum tissue and/or bone. The tooth may be in line with the other teeth, on the lip/cheek or tongue side of the mouth.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that an uncovering of the tooth is performed to allow an orthodontist to attach a button to guide the tooth into position in the mouth.

Expected Benefits. The purpose of uncovering of a tooth is to allow orthodontic treatment to be carried out to bring the tooth into functional alignment in the mouth. Without treatment the tooth may never, or at best very slowly move into position on its own.

Principal Risks and Complications. I understand that a small number of patients have difficulty with the procedure in that the tissue may relapse and cover the tooth during healing. Risks include damage to the gum, damage to teeth, damage to nearby nerves, reaction to the anaesthetic, and bleeding. Please also note that soft tissue grafting may be necessary in the future to provide adequate attached tissue around these teeth. This can be completed after orthodontic treatment in most cases.

I understand that complications may result from surgery or from anesthetics. These complications include, but are not limited to:
1) post-surgical infection,
2) bleeding, swelling and pain,
3) facial discoloration,
4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods,
5) allergic reactions, and
6) accidental swallowing of foreign matter.

The exact duration of any complications 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 surgery is not satisfactory. It is important to note that medications typically taken for osteoporosis, certain cancers as well as other disorders (bisphosphonates or other types of medication) such as Fosamax or Prolia may NOT allow proper healing and may cause additional damage to my bone and teeth.

Alternatives to Suggested Treatment. My periodontist has explained alternative treatments for my impacted tooth. These include no treatment and continued monitoring for progressive eruption.

Necessary Follow-Up and Self-Care. I understand that it is important for me to continue to see my regular dentist.
I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and

instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

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. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records. I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Governing Law. I agree that the relationship between me and the dentist shall be governed and construed in accordance with the laws of the province of Ontario.

Jurisdiction. I acknowledge that the treatment /service is to be performed in the province of Ontario, and agree that the courts of the province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment.

PATIENT CONSENT

I have been fully informed of the nature of a tooth uncovering procedure, the method to be utilized, the risks and benefits of such surgery, the alternative treatments available and the necessity for follow-up and self-care. I have had the opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of tooth uncovering procedure(s) as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

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Date

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(Printed Name of Patient, Parent or Guardian)

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(Signature of Patient, Parent or Guardian)

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Date

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(Printed Name of Witness)

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(Signature of Witness)