CONSENT FOR PERIODONTAL CROWN LENGTHENING SURGERY

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have short teeth that may prevent the healthy placement of restorations (fillings or crowns). These teeth are most often considered compromised and surgery is being considered to improve the functioning and long term prognosis of the tooth. Without crown lengthening the teeth are often non-restorable and thus may need to be extracted. I understand that lack of sufficient crown length may reduce the retention of some restorations and it may also create an unhealthy environment for the tissue around the restored teeth. Without crown lengthening, pockets may form between the restored tooth and gum. These pockets allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further erosion or loss of bone and gum supporting the roots of my teeth. It is unlikely that you would lose your teeth as a result of not having the procedure (crown lengthening) completed; however the tissue is more likely to become inflamed (red, puffy), bleed during home care and treatment in the future may compromise the aesthetics of your smile. The teeth may also appear short and require lengthening for aesthetic improvement alone or prior to restorations (veneers, crowns, fillings).

Recommended Treatment. In order to treat this condition, my periodontist has recommended that my treatment include crown lengthening surgery. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment.

During this procedure, my gum will be opened to permit better access to the roots and to the bone. Excess gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone may be reshaped and removed from around the tooth. My gum will then be sutured back into position and a periodontal bandage or dressing may be placed.

I further understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan. These may include, but are not limited to:
1) extraction of hopeless teeth,
2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or
3) termination of the procedure prior to completion of the surgery originally outlined.

Expected Benefits. The purpose of periodontal surgery is to reduce inflammation around restored teeth; improve the retention of future restorations; or improve the aesthetics of my smile by providing more ideal length to width ratios of my teeth.

Principal Risks and Complications. I understand that procedures such as crown lengthening surgery are designed to help keep compromised teeth as long as possible in a well functioning manner; however, a small number of patients do not respond successfully to crown lengthening surgery, and in such cases, the involved teeth may eventually be lost. Surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the periodontal surgery, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and 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 results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical condition, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, disease, symptoms, habits, or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all medications as prescribed are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. I understand that alternatives to periodontal surgery include:
1) no treatment - which may result in retentive problems for restorations in the future and/or chronic inflammation of the tissue around the restored teeth;
2) extraction of teeth with consideration of tooth replacements (implants, bridges, partial dentures).

Necessary Follow-Up and Self-Care. I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of crown lengthening.

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.

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 <u>NOT</u> allow proper healing and may cause additional damage to my bone and teeth.

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 crown lengthening surgery, the procedure to be utilized, the risks and benefits of periodontal crown lengthening 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 periodontal surgery 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

_____ _____

Date (Printed Name of Patient, Parent or Guardian)

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(Signature of Patient, Parent or Guardian)

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Date (Printed Name of Witness)

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(Signature of Witness)