



Festina Lente

**Integrative Periodontology
and Implant Center**

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CONSENT FOR ALLOGRAFT (Gum Graft) SURGERY

_____ I hereby authorize
Patient Name

Sofia Petrov DDS, MSD, and any associates to perform connective tissue graft surgery on

tooth/teeth numbers: _____.

Diagnosis: Healthy teeth are surrounded by two types of tissue: gingival and mucosa. Mucosa is like cheek tissue and does not adhere to the roots of the teeth or underlying jawbone very well as compared to gingival, which is a more firm, fibrous tissue. If mucosa is present at the gum line of the teeth or is the only gum tissue adhered to the root of the tooth, it is more likely to recede which can expose the root and may cause a loss of the underlying jawbone around the tooth. Having a good amount of healthy jawbone around the teeth is essential, as this is what holds the teeth in place.

After a careful oral examination and study of my dental condition, my doctor has advised me that I have an insufficient amount of attached gingiva (firm gum tissue) around some teeth. With this condition, recession of the gum may occur. In addition, it is important to have a sufficient amount of firm, adhered gingiva to the roots of the teeth for fillings or crowns with edges under the gum line to withstand the irritation they may cause. Gingiva (firm gum tissue) also improves appearances and protects the roots of healthy teeth.

Recommended Treatment: In order to treat this condition, my doctor has recommended that my treatment include gingival grafting (gum grafting). I understand that a local anesthetic will be administered to me as a part of the treatment. I understand that my own gum tissue provides the most predictable result; however other options are available to me such as donor tissue should I choose not to use my own gum tissue. These substitutes are safe and generally associated with good results.

Gum grafting involves transplanting of a thin strip of gingiva from the palate (roof of the mouth) and sutures will be placed on the palate. The existing gum tissue around the teeth to be grafted will be excised back, and the transplanted gingiva from the palate will be sutured in place. The existing gum will then be sutured over the grafted tissue. The sutures on the palate fall out in about 2-3 days, and the sutures around the grafted tooth will dissolve in about 3-4 weeks. In some cases, it is necessary to refine the area like a scar revision 3-4 months following the procedure. This is usually done with a dermatology-type carbon dioxide laser.

If a transplant is placed so as to partially cover the tooth root surface exposed by the recession, the gum placed over the root may shrink back during healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession or with increased spacing between the teeth. The transplanted tissue is received from a donor site usually located in the palate.

Occasionally an alternative tissue may be used, such as AlloDerm, an acellular dermal matrix from a tissue bank.

Expected Benefits: The purpose of gingival grafting is to create an amount of attached gum tissue adequate to reduce the likelihood of gum recession. It is also intended to cover some of the exposed roots of the tooth/teeth. However, do not expect the entire exposed tooth root caused by existing gum recession to be completely re-covered with this gum graft surgery, as that may not happen.

Principal Risk and Complications: I understand that a small number of patients (approximately 5%) do not respond successfully to the grafting procedure. The usual causes are excessive shrinking of the graft tissue while healing, smoking, or the graft being knocked loose during the initial healing phase. If this occurs, it may be necessary to re-do the surgery after approximately 3 months to allow the surgical sites to heal. Usually, but not always, the second graft will be successful.

Some complications may result from the gingival graft surgery or from drugs/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 lip, tongue, teeth, chin, or gum, jaw joint looseness, tooth sensitivity to hot, cold, sweet or acidic foods, cracking or bruising of the corners of mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, injury to teeth, adverse 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.

Alternatives to Suggested Treatment: Alternatives to the grafting surgery is no treatment – with the expectation of possible advancement of my condition which may result in premature loss of teeth.

Necessary Follow-Up Care and Self-Care: I understand that it is important for me to continue to see my general dentist for routine dental care. Smoking may adversely affect gum healing and may limit the successful outcome of my surgery. Studies show that smokers have more failed grafts than non-smokers. I know I should only use soft bristle toothbrushes or soft electric toothbrushes going forward. Ongoing commitment to good oral hygiene is essential to my dental health.

I have notified my doctor of any pertinent medical conditions I have, known allergies (especially to medications or sulfites), and medications I am taking including over-the-counter medications, nutritional supplements, and herbs. I have informed my doctor of any present or past head or neck radiation therapy. I have told the doctor about any use of bisphosphonate medications including Zometa®, Aredia®, Boniva®, Fosamax®, or Actonel®.

I need to make and keep my post-operative appointments to ensure my healing is monitored and so that the outcome of the surgery can be determined and reported to my regular dentist.

I understand that smoking, excessive alcohol intake, or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery.

I know that it is important to:

- 1) Abide by the specific prescriptions and instructions given.
- 2) Attend my post-operative checks as needed.
- 3) Quit smoking.
- 4) Perform excellent oral hygiene once instructed to, usually starting 2 weeks after the surgery is complete.
- 5) Have the graft area reshaped if it is needed several months later, usually with a carbon dioxide laser. There is no extra charge for this.

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, 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 doctor cannot predict the absolute certainty of success. There exist the risks of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best care.

Publications 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 for

reimbursement purposes. My identity will not be revealed to the public, however, without my permission.

Communication with My Insurance Company, My Dentist, or Other Dental/Medical Providers:

I authorize sending correspondence, reports, chart notes, photos, x-rays, and other information pertaining to my treatment before, during, or after its completion with my insurance carriers, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I should consult with my physician about an additional form of contraceptive to be used for one complete cycle after a course of antibiotics is completed.

Patient Consent for Connective Tissue Graft (Gum Graft) Surgery

I have been fully informed of the nature of connective tissue graft (gum graft) surgery, the procedures to be utilized, the risks and benefits of such surgery, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask questions I have in connection with the treatment and to discuss my concerns with the doctor. After thorough deliberation, I hereby consent to the performance of the procedures 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 doctor.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Date

Printed Name of Patient, Parent, or Guardian

Signature of Patient, Parent, or Guardian

Date

Printed Name of Doctor

Signature of Doctor