Festina Lente

Integrative Periodontology and Implant Center

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CONSENT FOR EXTRACTION AND RIDGE PRESERVATION

_____ I hereby authorize
Patient Name

Sofia Petrov DDS, MSD, and any associates to perform Extraction Surgery on

tooth/teeth numbers: _____.

Diagnosis: After a thorough examination of my dental condition, my periodontist has advised me that I present a tooth/teeth which requires removal. She further informed me that natural bone healing would lead to an insufficient amount of bone to replace the tooth with a dental implant.

Recommended Treatment: In order to treat my condition, my periodontist had recommended that a ridge preservation procedure be performed at the time of the extraction of my tooth. During this surgical procedure the gum around the extracted tooth will be opened to permit better access to the surrounding bone. A bone preserving membrane (resorb able or non-resorb able) will be adapted to the extraction site. A bone graft membrane (processed bone material of animal origin, bone material from a human bone bank or my own bone) may be used to enhance results.

Expected Benefits: It is expected that with this treatment, the extraction site will present sufficient dimension for optimal placement of a dental implant.

Principal Risk and Complications: I understand that even with ridge preservation, there is a reduction in bone dimensions. In some instances, this reduction may prevent implant placement.

If this is the case, I may require supplement bone grafting. Other risks include bleeding or infection after surgery, swelling, pain and facial discoloration (bruise). There is a very low risk of injury to a nerve when extracting lower molars and a low risk of sinus membrane perforation when extracting upper molars.

Alternatives to Suggested Treatment: Alternatives to periodontal surgery with bone regenerative surgery include 1) no treatment – with the expectation of possible advancement of my condition which may result in premature loss of teeth, 2) extraction of a tooth or teeth involved with periodontal disease, 3) non-surgical scraping of tooth roots and lining of the gum (scaling and root planning), with or without medication, in an attempt to further reduce bacteria and tartar under the gum line – with the expectation that this may not fully eliminate deep bacteria and tartar and may not reduce gum pockets, will require more frequent professional care and time commitment, and may not arrest in the worsening of my condition and the 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. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my doctor may make recommendations for the placement of restorations, the replacement of existing restorations or their modification, the joining together of two or more of my teeth, the extraction of two or more of my teeth, the performance of root canal therapy, or the movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects, which would become my sole responsibility.

I understand that smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to abide by the specific instructions given by my periodontist.

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 the doctor 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 healing outcome of my surgery. I know that it is important 1) to abide by the specific prescriptions and instructions given by my doctor and 2) to see my doctor and dentist for periodic examination and preventative 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, 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 viewing of my care and treatment during or after its completion to be used for either the advancement of general dentistry or in promotional materials. My identity will not be revealed to the general public.

Communications with Insurance Company, my dentist, or other medical/dental health 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 have who may have a need to know about my dental treatment.

Patient Consent for Extraction and Ridge Preservation

I have been fully informed of the nature of periodontal surgery and bone regenerative procedures, 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 periodontal surgery and bone regenerative 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.

It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

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