Discussion and Informed Consent for Gingival (Gum) Graft

Patient Name: _____ Date: _____

Diagnosis: _____

Treatment and Site: _____

Facts for Consideration

Patient's initials required

_____ I have been informed that I have a mucogingival (gum) problem around some of my teeth. This may mean I have insufficient attached gum tissue or a muscle attachment that could potentially cause the premature loss of teeth. I understand that where there is insufficient attached gingiva (gum), bacteria and food can become lodged under the gum line and this may result in further recession of the gum or localized infection (gum abscess). I also understand that where there are fillings at the gum line or crowns (caps) with edges under the gum line, it is important to have sufficient width of attached gingiva (gum) so that the edges of the fillings or crowns or the material from which they are made do not cause significant irritation to the gum. I have been advised and understand that gingival graft surgery can help this problem.

_____ It has been explained to me that the surgical procedure involves the removal of a thin strip of gum generally from my mouth (usually the roof of the mouth) and transplanted/placed near the area of gum recession. The transplant can be placed at the base of the remaining gum or it can be placed to partially cover the tooth root surface exposed by the recession. If the latter is attempted, I understand that the gum placed over the root may shrink back during healing and that the attempt to cover the exposed root surface may not be completely successful.

_____ After a local anesthetic by injection has numbed the area to be operated, the gums will be reflected (incised) to expose the teeth and the roots of the teeth will then be cleaned and smoothed. Antibiotics and/or other chemicals may be applied to the roots to decontaminate them before the graft material is placed in the area(s).

Benefits of Gingival Graft, Not Limited to the Following:

_____ The goal of the gingival grafting procedure is to strengthen the grafting site(s) by adding new keratinized (denser) attached gingiva to the area that can resist any future breakdown. This procedure can also cover exposed root surfaces, enhancing the appearance of the teeth and gum line and treating and minimizing root sensitivity or decay.

Risks of Gingival Graft, Not Limited to the Following:

_____ I understand with surgery that there may be postoperative bleeding, swelling, pain, infection, facial discoloration and temporary or, on occasion, permanent tooth sensitivity to hot, cold, sweet or acidic foods. A temporary or permanent numbing of the surgical areas, including the gums, lips and chin, may occur.

_____ I understand that a small number of patients do not respond successfully to gingival grafting. If a transplant is placed to partially cover the tooth root surface exposed by recession, the gum placed over the root may shrink back during the healing. In such a case, the attempt to cover the exposed root surface may not be completely successful resulting in more recession or increased spacing between the teeth. The graft may appear different in color and thickness from the adjacent soft tissue.

_____ I understand that I will receive a local anesthetic by injection and/or other medication(s). In rare instances, patients have a reaction to the anesthetic, which may require emergency medical attention or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. **Depending on the anesthetic and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection resulting in loss of feeling in the chin, lips, gums and tongue and loss of taste**.

_____ I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____ I understand that ALL medications have the potential for side effects, unintended reactions and drug interactions. Therefore, it is critical that I tell my dentist of all medications and supplements I am currently taking, which are: _____

_____ I am_____/I am not_____currently or in the past taken bisphosphonates for the purpose of treating osteoporosis.

_____ I understand that smoking and/or chewing tobacco and/or alcohol intake may effect gum healing and may limit or prevent the successful outcome of my surgery. Smoking may adversely affect the extraction site healing and may cause dry socket (an infection of the bone of the socket walls). Smokers are at higher risk for dry socket and have more dry sockets than nonsmokers. I agree to follow instructions related to the daily care of my mouth.

Alternatives to Suggested Treatment:

_____ I understand that alternatives to gingival grafting may include (1) no treatment, with the expectation of chronic inflammation resulting in the advancement of recession, which is commonly associated with increased sensitivity of the teeth to temperature extremes and other irritants, increased risk of decay in root surfaces exposed by the recession and possibly the premature loss of teeth; (2) attempts to insulate teeth to control sensitivity by placing fillings in or on root surfaces with the expectation of further recession as a result of this procedure; (3) nonsurgical scraping of tooth roots and lining of the gum (root planing and curettage) with the expectation that this will result in only a partial and temporary reduction of inflammation and infection, will not stop recession, will require more frequent professional care and may result in the worsening of my condition and the premature loss of teeth; (4) extraction of teeth involved with recession and a lack of attached gum tissue, which may need replacement with bridges, crowns or dental implants.

Alternatives Discussed: _____

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Check the boxes below that apply to you:

Consent

☐ I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed gingival graft.

☐ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.

☐ I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. _____ to do whatever he/she deems necessary and advisable under the circumstances.

☐ I consent to have the above-mentioned treatment.

☐ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

or

Refusal

☐ I refuse to give my consent for the proposed treatment(s) described above and understand the potential consequences associated with this refusal.

_____ _____

Patient or Patient's Representative Date

_____ _____

Witness Signature Date

I attest that I have discussed the risks, benefits, consequences and alternatives of the above treatment with _____ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consents or refuses treatment noted above.

_____ _____

Dentist Signature Date