Consent for Soft Tissue Augmentation & Root Coverage surgery

Babak Noohi, DDS, MS, CAPITOL HILL DENTISTRY

Patient's name:

Referred by Dr.

Diagnosis. After a careful oral examination and study of my dental condition, Dr. Noohi has advised me that I have significant gum recession. I understand that with this condition, further recession of the gum may occur. In addition, for fillings at the gum-line or crowns with edges under the gum-line, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Gum tissue may also be placed to improve appearance and to protect roots of the teeth.

Recommended Treatment. In order to treat this condition, Dr. Noohi has recommended that ridge augmentation (gum grafting) procedures be performed in areas of my mouth with significant gum recession. I understand that a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the transplanting of a thin strip of gum from elsewhere in my mouth. The transplanted strip of gum can be placed at the base of the remaining gum, or it can be placed so as to partially cover the tooth root surface exposed by the recession. A periodontal bandage or dressing may be placed.

Expected Benefits. The purpose of ridge augmentation is to create an amount of attached gum tissue adequate to reduce the likelihood of further gum recession. Another purpose for this procedure may be to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, or to prevent or treat root sensitivity or root decay.

Principal Risks and Complications. I understand that a small number of patients do not respond successfully to ridge augmentation. If a transplant is placed so as to partially cover the tooth root surface exposed by the recession the gum placed so as to partially cover the tooth root surface exposed by the 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. Indeed, in some cases, it may result in more recession or with increased spacing between the teeth.
I understand that complications may result from ridge augmentation 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, (7) numbness of the lower lip, gum or jaw. 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. In addition, the success of ridge augmentation can be affected by (1) medical conditions, (2) dietary and nutritional problems, (3) smoking, (4) alcohol consumption, (5) clenching and grinding of teeth, (6) inadequate oral hygiene, and (7) medications that I may be taking. To my knowledge I have reported to Dr. Noohi any prior drug reactions, allergies, diseases, 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 Dr. Noohi and taking all prescribed medications are important to the ultimate success of the procedure.

Alternatives to Suggested Treatment. Dr. Noohi has explained alternative treatments for my gum recession, and modification of technique for brushing my teeth.

Necessary Follow-up Care and Self-Care. I understand that it is important for me to continue to see my regular dentist (if other than Dr Noohi). Existing restorative dentistry can be an important factor in the success

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or failure of ridge augmentation. 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 Dr. Noohi can evaluate and report on the outcome of surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by Dr. Noohi, and (2) to see Dr. Noohi and/or General 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, 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, Dr. Noohi cannot predict certainty of success. There is risk of failure, relapse, additional treatment, or even worsening of my present condition, despite the best of care.

Use of Records for Reimbursement Purposes. I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for reimbursement purposes. In furtherance of the progression of dentistry and the dental health of the public, I do hereby consent to photographs being taken of my oral and facial structures, and subsequent publication solely for the educational and scientific purposes. These photographs will be exposed in such a way as to protect my anonymity.

PATIENT CONSENT

I have been fully informed of the nature of ridge augmentation surgery, the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Noohi. After thorough deliberation, I hereby consent to the performance of soft tissue ridge augmentation surgery as presented to me during consultation and in the treatment plan presentation as described in the document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Noohi.

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]	[Signature of witness/ Dental Assistant]	[Printed name of witness/ Dental Assistant]

Babak Noohi, D.D.S., M.S.

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