Mark Sebastian D.M.D
Practice Limited to Periodontics and Dental Implants
33516 Ninth Avenue South, #2
Federal Way, WA 98003
(253) 941-6242
(253) 952-2129 fax
www.fwperio.com

Consent for Periodontal Surgery with Bone Regenerative Procedures

Diagnosis: After a careful examination and study of my dental condition, my periodontist has advised me that I have periodontal disease. I understand that periodontal disease weakens support of my teeth by separating the gum from the teeth and possibly destroying some of the bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum line and can result in further erosion or loss of bone and gum supporting the roots of my teeth. If untreated, periodontal disease can cause me to lose my teeth and can have other adverse consequences to my health. Periodontal disease is the primary cause of tooth loss in adults.

Recommended Treatment: In order to treat this condition, my periodontist has recommended that my periodontal treatment include bone regenerative surgery. Local anesthetic will be administered to me as part of the treatment. Antibiotics and other substances may be applied to the roots of my teeth.

During this procedure, the gums will be opened to permit better access to the roots and the eroded bone. Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned. Bone irregularities may be reshaped.

Graft material will be placed in the areas of bone loss around the teeth. Various types of graft materials may be used. These materials may include my own bone, synthetic bone substitutes, animal bone material (cow or pig) or bone obtained from tissue banks (human donors). Membranes (synthetic or animal (cow or pig)) may be used with or without graft material, depending on the type of bone defect present. My gum will be sutured back into position over the above materials, and a cast bandage (dressing) may be placed around the teeth.

I 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 to enhance healing of adjacent 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 all of the surgery originally outlined.

Initials_____

Expected Benefits: The purpose of periodontal surgery is to reduce infection and inflammation and to restore my gum and bone to the extent possible. The surgery is intended to help me keep my teeth in the operated areas and to make my oral hygiene more effective. It should also enable dental professionals to better clean my teeth during regular teeth cleanings. The use of bone, bone graft material or the placement of a membrane is intended to enhance bone and gum healing.

Principal Risks and Complications: I understand that some patients do not respond successfully to bone regenerative procedures. The procedure may not be successful in preserving function. Because each patient's condition is unique, long term success may not occur and in such case, some of the involved teeth may eventually be lost.

Complications that may result from surgery could involve the surgery procedure, bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, 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, accidental swallowing of foreign matter, and transient (on rarest of occasions permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. The exact duration of any complication 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. There may be a need for a 2nd procedure if the initial results are not satisfactory. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, snuff and chewing tobacco, 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 reaction, allergies, diseases, symptoms, habits or conditions that 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 prescribed are important to the success of the procedure.

Alternatives to suggested Treatment: I understand that alternatives to periodontal surgery include: 1) No treatment with the expectation of probable advancement of my periodontal (gum) condition which may result in premature loss of teeth; 2) extraction of the teeth involved with periodontal disease; 3) non-surgical scraping of tooth roots and lining of the gum (scaling and root planning), with or without local or systemic medication, in an attempt further to reduce bacteria and tartar under the gum line, with the expectation that this may not fully eliminate deep bacteria and tartar, may not reduce gum pockets, will require more frequent professional care and time commitment, and may not arrest the worsening of my condition and the premature loss of teeth. Bone loss that advances too far along may not be treatable at a later date.

Initials_____

Necessary Follow-up Care and Self-Care: It is important for me to continue to see my regular dentist for routine dental care and to get the missing tooth/teeth replaced as recommended.

I understand smoking and smokeless tobacco may adversely affect healing and may cause pain and/or a poor result, especially if used during the 1st month, If you must smoke, keep it under 5 cigarettes a day and only smoke the 1st half of the cigarette and discard it. No smokeless tobacco.

I should not use a water-pik for 3 months

I have told Dr. Sebastian about any pertinent medical conditions I have, known allergies (especially to medications or sulfites (many local anesthetics have sulfite preservatives)), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Sebastian about any present or prior head and neck radiation therapy.

I have told Dr. Sebastian about any present or prior use of bisphosphonate medications. Some common brand names are Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®.

I need to come back in for several post-operative check-ups so that healing may be monitored and so Dr. Sebastian can evaluate and report on the outcome of surgery to my dentist. It may be necessary to remove both non-resorbable sutures and non-resorbable membranes used in the bone regeneration surgery.

I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr Sebastian for post-operative check-ups as needed.
3. Not smoke or use smokeless tobacco for 1 month as noted above.
4. Avoid water-piks for at least 3 months.
5. Have any non-dissolvable sutures (stitches) and membranes removed.
6. Get the tooth/teeth replaced as recommended.

No Warranty or Guarantee: While in most cases the surgical area heals quickly and with out any problems, complications such as those listed previously, can happen despite the best of care.

Publication 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 dentistry, in written or internet publications or sites, and in promotional materials. My identity will not be revealed to the general public.

Initials_____

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 will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Procedure(s) to be performed:

Patient Consent

I have been informed of the nature of this periodontal 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 and opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with Dr. Sebastian and his staff members. After thorough deliberation, I hereby consent to the performance of periodontal surgery as presented to me during consultation as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Sebastian.

_____ _____

Date [Printed name of patient, parent or guardian]

_____

[Signature of patient, parent or guardian]

_____ _____

Date [Printed name of witness]

_____

[Signature of witness]