Patient's name: _____

INFORMED CONSENT PERIODONTAL PROCEDURES

I UNDERSTAND that periodontal surgical procedures (treatment involving the gums and other tissues supporting the teeth) have been recommended to me to treat the presence/effects of Periodontal Disease, Gingival Recession, Inadequate Gingival support/thickness and/or Bone Loss.

I UNDERSTAND that all oral surgery procedures include certain risks and the possibility of failure or relapse. I agree to assume these risks associated with but not limited to the following:

1. **Response to treatment**: Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process in which tissue response is a vital element will achieve the results desired. Even though the utmost care and diligence will be exercised in your Periodontal treatment, there are no promises or guarantees as to anticipated results.

2. **Prospective patient responsibility for care**: With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment as instructed by the treating dentist. Without the necessary follow-up care by the patient, the probability of unsatisfactory results is greatly increased.

3. **Pain and soreness**: Periodontal surgery is oftentimes followed with mild to substantial pain and soreness in the gums and bony tissues. This must be expected and instructions will be given as to the methods of controlling the problems of pain and soreness.

4. **Bleeding, bruising, and swelling**: Following periodontal surgery, there are occasions when bleeding may occur. Instructions as to how this may be controlled will be given you. Some bruising and/or swelling of the intra-oral and facial tissues may occur. If extreme, it is your responsibility to contact this office.

5. **Infection**: On occasion, postoperative infection(s) may occur. Secondary infections can prevent or disturb appropriate healing and final results. Please contact our office immediately should you have any concerns relating to your healing.

6. **Reaction to medications and anesthetics**: Allergic reactions to medications, materials, and/or anesthetics may exhibit themselves at the time or after surgery that will require the immediate removal of medication or material and replacement of an appropriate alternative. It is the responsibility of the patient to fully inform the doctor of any past and current allergic reactions.

7. **Injury to the nerves**: Invasive surgical procedures can possibly result in injury to the nerves of the lips, tongue, or other oral tissues. These injuries could result in temporary to permanent numbness. Please inform the doctor immediately if any treated areas experience prolonged or altered sensations.

It is the patient's responsibility to seek attention should any undue circumstances occur postoperatively and the patient shall diligently follow any preoperative and postoperative instructions given them, including the scheduling and attending each and every appointment.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may or may not occur. By signing this form, I am freely giving my consent to allow and authorize Dr. Robert M. Flynn and/or his associates to render any treatment necessary or advisable to treat my dental conditions, including any and all anesthetics and medications.

X_____ Date: _____

Signature of patient/legal guardian/authorized representative

X_____ Date: _____

Signature of Witness