DAVID B. KRILL, D.M.D., INC.

PERIODONTICS AND ORAL DIAGNOSIS
10475 MONTGOMERY RD.
SUITE 1-H
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(513) 891-3933
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An explanation of your need for periodontal flap surgery, the procedure and post-operative care, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo this procedure. Please read this document which repeats issues we discussed and provide the appropriate signatures on the last page. Please ask us to clarify anything that you do not understand.

PATIENT'S CONSENT FOR PERIODONTAL GINGIVECTOMY SURGERY

DIAGNOSIS: I have been informed of the presence of periodontal disease in my mouth and that this involves the weakening of support to my teeth by first producing a separation of the gum from the teeth (pockets.) This allows for the greater accumulation of bacteria under the gum in hard to clean areas and that this can result in my body's defense reactions or infection resulting in the erosion or loss of bone supporting the roots of my teeth.

SUGGESTED TREATMENT: It has been suggested that my treatment include periodontal flap surgery.

PURPOSE OF PERIODONTAL FLAP SURGERY: I have been informed that the purpose of this procedure is to allow access for the cleaning of the roots of teeth and the lining of the gum, as well as to treat irregularities to the jaw bone surface, so that when the gum is replaced about the teeth, it will allow for the reduction of pockets, infection and inflammation. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and of the ability of professionals to better clean my teeth of tartar and bacteria. The reduction of infection and inflammation should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated area(s.)

ALTERNATIVES TO THE SUGGESTED TREATMENT: These may include: (1) no treatment with the expectation of the advancement of my condition resulting in the possible premature loss of teeth; (2) extraction of teeth involved with periodontal disease; (3) attempts to further reduce bacteria and tartar under the gumline by non-surgical scraping of tooth roots and lining of the gum (root planing and curettage) with the expectation that this will not fully eliminate deep bacteria and tartar, result in only a partial and temporary reduction of inflammation and infection, will not reduce gum pockets and will require more frequent professional care and my result in the worsening of my condition and the premature loss of teeth.

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NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating pockets, infections or further bone loss or recession. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth by reducing the likelihood of further gum recession in the treated area (s,) but due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective, retreatment, or worsening of my present condition care.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested 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.

SUPPLEMENTAL RECORDS & THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

PATIENT'S SIGNATURE: My endorsement (signature) to this form indicates that I have read and fully understand the terms and works within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to gingival graft surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

_____	_____	_____ of
Patient's signature (signature of Parent or Legal Guardian if the patient if a minor)	Date	Relationship to Patient

_____
Patient's Name

_____	_____
Signature of Witness	Date

_____	_____
Signature of Doctor	Date