



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

PERIODONTICS AND ORAL DIAGNOSIS
8221 CORNELL ROAD
CINCINNATI, OH 45249
(513) 891-3933
FAX (513) 891-5979

An explanation of your need for surgical exposure of impacted teeth, the procedure and post-operative care, it's purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your evaluation, 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 SURGICAL EXPOSURE OF IMPACTED TEETH

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of an impacted tooth below the gum line in my mouth. I understand that it is important to have this tooth exposed for orthodontic (braces) purposes.

PURPOSE OF EXPOSURE: I have been informed that the purpose of surgical exposure of an impacted tooth for continuation of my orthodontics.

SUGGESTED TREATMENT: It has been suggested that surgical exposure be performed in areas of my mouth where I have an impacted tooth. It has been explained that this is a surgical procedure involving the removal of gum and possibility bone from the associated tooth or teeth and possible placement of an orthodontic bracket.

RISK RELATED TO THE SUGGESTED TREATMENT: Risks related to surgical exposure surgery might include but are not limited to post-operative bleeding, numbness, swelling, pain, infection, facial discoloration, transient or on occasion permanent tooth sensitivity to hot or cold or sweets or acidic foods. Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

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. 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, 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 including the possibility of losing certain teeth with advanced involvement despite the best of care.



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COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may effect 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 radiographs 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 words 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 periodontal flap surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

Patient's Signature
(Signature of Parent
or Legal Guardian if
the patient is a minor)

Date

Relationship to patient

Patient's Name

Signature of Witness

Date

Signature of Doctor

Date