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

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

PATIENT'S CONSENT FOR GINGIVAL GRAFT SURGERY

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of significant gum recession in my mouth. I understand that it is important to have a sufficient width of gum (attached gingival) around the base of the teeth (at the gumline) such that it minimized the probability of food particles and bacteria lodging between the gum and teeth. I understand that where there is insufficient attached gingival (gum) food or bacteria become lodged under the gumline. This may result in further recession of the gum or in a localized infection (gum abcesses). I also understand that it is not possible to cover fillings with gingival (gum) tissue, if fillings exist along the edge of the gingival (gum).

PURPOSE OF GINGIVAL GRAFTING: I have been informed that the purpose of this procedure is to create an adequate band (width) of attached gum tissue so as to prevent the likelihood of further gum recession.

SUGGESTED TREATMENT: It has been suggested that gingival grafting be performed in areas of my mouth where I have significant gum recession. It has been explained that this is a surgical procedure involving the removal of a thin strip from the roof of my mouth, alongside the upper teeth, and transplanting it to the area of significant gum recession. There, it 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. If the latter is attempted, I understand the gum placed over the root may shrink back during healing and that the attempt to cover the exposed root surface may not be completely successful.

RISK RELATED TO THE SUGGESTED TREATMENT: Risks related to gingival grafting surgery might include but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, transient, but 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 in eradicating pockets, infections or further bone loss or recession. It is anticipated (hoped) that the surgery will provide benefit in improving 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, despite the best of care.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgery plan. These may include but are not limited to discontinuing the procedures prior to completion of all the surgery originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may effect 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 photograph, 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 indicated 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	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	
_____	_____	
Signature of Doctor	Date	