NOSE
CREEK
DENTAL
CENTRE

Date Procedure completed _____

Gingival Graft Consent

This is my consent for Dr. Townsend to perform the following procedure:

_____

The doctor and/or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this procedure or doing nothing at all.

My dentist has explained forms of treatment. I have chosen the Gingival Graft to provide stability for further treatment.

I understand that if I decide not to undertake any treatment, the following complications can occur; worsening of the gingival recession, root cavities, periodontal disease, tooth mobility and sensitivity that may require extraction.

I am aware that ONE WEEK PRIOR to treatment that I will stop taking fish oils/vitamin E Supplements.

I have been informed of the risks and complications involved with this surgery, medications, and anesthesia. These complications can include pain, swelling, infection and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible.

I am aware that each patient heals in a different manner after graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

I understand that smoking, vaping, drinking alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post-operative instructions from my dentist. I will respect appointments and have my bone graft checked as well as have regular hygiene checkups.

To my knowledge, I have given the proper medical information in regard to my physical and mental states (medications, disease, syndromes, etc.) I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition, I have mentioned any abnormal reaction of the gums, skin, and abnormal bleeding, or any condition related to my overall health.

_____ _____

Signature of Patient/Parent or Guardian Dr. Scott Townsend

_____

Patient Name

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