American Dental

AUTHORIZATION AND INFORMED CONSENT FOR PERIODONTAL SURGERY

Patient_____ ID: _____ HR:_____- ____/____

I hereby authorize and request Dr. Rauf Yousuf to perform upon me the following treatment/procedure/surgery:

_____Osseous Surgery (Quads____)
_____Gingival Flap Procedure (Quads____)
_____Bone Grafts
_____Soft Tissue Allograft (Alloderm)
_____Crown Lengthening (Tooth #s____)
_____Frenectomy
_____Free Soft Tissue Graft
_____Gingivectomy
_____Connective Tissue Graft
_____Root Resection
_____Biopsy

I also authorize and request the administration of such anesthetic or anesthetics, as may be deemed advisable by the Doctor.

Post-operative risks of the proposed surgery may include, but are not limited to:

- Swelling
- Pain
- Thermal Sensitivity
- Food Impaction between Teeth
- Infection
- Post-operative Bleeding
- Phonetic Interferences

Gum Recession
Exposure of Crown Margins
Tooth Mobility
Temporary Restricted Mouth Opening
Parasthesia
Damage to adjacent teeth

I have been informed that the purpose of the operation(s) is to surgically treat and possibly correct my periodontally diseases gums and their supporting bone.

If any unforeseen condition should arise in the course of the operation, calling for the Doctor's judgment and for the procedures in addition to or different from those now contemplated, I further request and authorize the Doctor to do whatever he may deem advisable.

Due to the presence of sever alveolar bone loss; the following teeth_____ may be extracted during treatment.

No guarantee, warranty or assurance had been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. It has been explained to me the long-term success of treatment requires my co-operation and performance of plaque control (home care) at least twice each day, as well as PERIODIC periodontal maintenance visits after the proposed treatment dental office.

I hereby certify, that I have read and fully understand the above consent to the operation, the explanation therein referred to or made, and that all blanks or statements requiring insertion or completion were completed before I signed.

Patient Signature _____ Date_____

Doctor's Signature _____

Assistant Signature _____ Date _____