**Consent for Flap/Osseous/Laser**

**Diagnosis**

After careful oral examination, my periodontist has advised me that I have periodontal disease, which is inflammation and infection of the gums and bone that surround and support the teeth.

**Recommended Treatment**

In order to treat this condition, my periodontist has recommended that periodontal surgery be performed. Surgery will involve the following steps:

- Administration of local anesthesia to numb the area
- Gums may be opened to permit better access to the roots and eroded bone
- Inflamed and infected gum tissue will be removed, and the root surfaces will be thoroughly cleaned
- Bone irregularities may be reshaped (osseous), and bone regenerative material may be placed around the teeth (guided tissue regeneration)
- Gums may be sutured back into position (osseous/flap)
- Post operative instructions and information on follow-up appointments

**Expected Benefits**

The purpose of this surgery is to stabilize the health and function of teeth, gums and bone that have been damaged due to periodontal disease.

**Risks of Periodontal Surgery**

I have been informed that this procedure carries the following risks:

- Swelling, bleeding, bruising or discomfort in the surgical area
- Post-Operative infection requiring additional treatment or medication
- Tooth sensitivity, tooth mobility (looseness) or tooth pain
- Gum recession/shrinkage creating open spaces between the teeth and making them appear longer
- Unaesthetic exposure of crown (cap) margins
- Numbness around the surgical area, and/or neighboring areas. Almost always the sensation returns to normal, but in rare cases, the lass may be permanent
- This treatment is not guaranteed to cure my periodontal disease and additional future treatment may be necessary

**Alternative Treatment Options**

- No treatment
- Scaling and Root Planing
- Tooth extraction

I hereby certify that I clearly comprehend the nature, purpose, benefits, risks and alternatives to (including no treatment), the proposed procedure(s). I have been given the opportunity to ask questions and they have been answered to my complete satisfaction.

I authorize photos, slides, x-rays or any other viewing of my care and treatment during of after its completion to be used for advancement of dentistry and reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

**Patient Name/Signature:_____ Date: _____**