CONSENT FOR EXPLORATORY PERIODONTAL SURGERY
11945 San Jose Blvd., Suite #101, Jacksonville, Florida 32223
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EXPLANATION OF DIAGNOSIS: 1) I have been informed that gum flap access will allow Dr. Young to diagnose and recommend treatment for the area of concern (i.e. possible fracture or other pathology).

PURPOSE OF EXPLORATORY SURGERY: I have been informed that the purpose of exploratory surgery is to evaluate my current disease without the gum tissue in the way, preventing accurate diagnosis. Once the flap is performed and Dr. Young has made a definitive diagnosis, further treatment may take place at that time.

SUGGESTED TREATMENT: It has been explained that this is a surgical procedure involving the gentle opening of the tissue around the tooth/teeth involved, cleaning out the infection or infected tissue, and diagnosing the underlying cause of the pathology/disease.

RISKS RELATED TO SUGGESTED TREATMENT: While this could be considered a low risk procedure, risks related to gingival surgery might include, but are not limited to, post-operative bleeding, swelling, pain, infection, facial discoloration, transient or, on occasion, permanent tooth sensitivity to hot or cold, sweets or acidic foods. Risks related to the local 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. There exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. I 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 affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery so that healing may be monitored and the doctor can evaluate and report on the success of surgery.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, video recording and x-rays 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 ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to gingival surgery as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

____________________________  _________________________  _________________________
Patient’s Signature                          Date                          Patient’s Name (please print)

____________________________  _________________________  _________________________
Signature of Patient’s Guardian              Date                          Relationship to Patient

____________________________  _________________________
Signature of Witness                           Date

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