

PATIENT _____

AGE _____

I hereby authorize and request _____ to perform upon me the following treatment/procedure/surgery:

- | | |
|--|---|
| <input type="checkbox"/> Osseous Surgery | <input type="checkbox"/> Free Soft Tissue Graft |
| <input type="checkbox"/> Guided Tissue Regeneration (Bio-gide) | <input type="checkbox"/> Gingivectomy |
| <input type="checkbox"/> Sinus Lift Elevation | <input type="checkbox"/> Emdogain |
| <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Biopsy |
| <input type="checkbox"/> Frenectomy | <input type="checkbox"/> Sinus Lift Elevation |
| <input type="checkbox"/> Alloderm | |

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, gum recession, exposure of margins of crowns, tooth mobility, food impaction between teeth, temporary restricted mouth opening, infection, parathesia, post operative bleeding, damage to adjacent teeth, and phonetic interferences.

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

If any unforeseen condition should arise in the course of the operation, calling for the Doctor's judgement or for 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 severe alveolar bone loss:

R 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 L

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 may be extracted during treatment.

No guarantee, warranty or assurance has been given to me that the proposed treatment will be curative and /or successful to my complete satisfaction. It has been explained to me that the long-term success of treatment requires my cooperation and performance of plaque control (home care) at least twice each day, as well as periodic periodontal maintenance visits after the proposed treatment at a dental office. **Publication of Records.** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

I certify that I have read fully and 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