SAN ANTONIO
PERIODONTICS & IMPLANTS
4501 McCullough Ste 104, San Antonio, TX 78212
Tel: 210.824.0111 **www.sanantonioperioandimplant.com**

GINGIVAL AUGMENTATION INFORMATION AND CONSENT FORM

I have been informed and I understand the purpose and nature of the proposed gingival augmentation procedure(s). I understand what is necessary to accomplish this procedure.

My doctor has carefully examined my mouth. Alternatives to this treatment have been explained, including no treatment. I havetried or considered these methods and I desire the gingival augmentation procedure.

With this consent form, I am being informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include, but are not limited to, numbness of the lip, tongue, chin, cheek, gums or teeth, pain, swelling, infections, bleeding, vertigo and discolorations. The exact duration may not be determinable and may be irreversible. Also possible are injury to teeth or adjacent structures, delayed healing, adverse reaction or allergy to drugs or medications used, etc., as well as TMJ (jaw joint) problems such as headaches, referred pain to the back of the neck, facial muscles and tired muscles from chewing.

I understand that if nothing is done, any of the following could occur: further recession, gum tissue inflammation and sensitivity.

My doctor has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following surgical procedures. In some instances, gum augmentation procedures fail and may need to be revised/redone at a later date. I have been informed and I understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

I understand that excessive alcohol, sugar intake, smoking and poor oral hygiene may effect gum healing and may limit the success of the procedure. I agree to follow my doctor's home care instructions and to report to him for regular examinations as instructed.

To my knowledge, I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health including a history of taking medications that may alter bone physiology (bisphosphonates such as Fosamax, Boniva, Actonel, Zometa etc.).

I request and authorize medical/dental and surgical services for me. I fully understand that during and following the contemplated procedure(s), surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve any modification in design, material or care, if it is felt this is in my best interest.

Patient's (or Legal Guardian's) Signature	Date
Wintess	Date
Patient's Name	Tooth Number/Area