MICHAEL C. STYPULA, D.D.S., M.D.S.
2555 Washington Road, Suite 621
Pittsburgh, PA 15241

CONSENT TO PERIODONTAL (GUM) SURGERY

I hereby authorize Dr. Michael Stypula to perform periodontal surgery upon (Name of Patient)_____in these areas of the mouth_____.

I have been informed that the purpose of the surgery is to treat my diseased gum tissue, teeth and supporting bone, or to rebuild lost tissues including hard or soft tissue, or to elongate tooth structure for restorative purposes.

This type of surgery is performed after administering a local anesthetic that typically contains a vasoconstrictor depending on your particular medical history.

If I have requested or agreed to have sedative drugs (pills) or intravenous sedation, I will not drive myself home after surgery, I will arrange to be driven home and accompanied while the sedative drugs still have an affect (usually 2-4 hours) by; (name of care giver)_____.

If any unforeseen conditions should arise during, surgery, calling for procedures in addition to or different from those discussed, I authorize Dr. Michael Stypula to do whatever he may deem advisable and in my best interest (including extraction of involved teeth, alteration of surgical procedure, or discontinuation of procedure).

I have been informed that alternatives to surgical treatment include: doing nothing; extracting involved teeth or receiving frequent, repetitive deep scaling and root planning in an attempt to slow down the disease process. However, I have agreed to have the surgical treatment to more directly treat the problem/s in my mouth.

If a bone graft or soft tissue graft is performed in an attempt to rebuild lost bone or improve tissue contour, I realize several substances may be used. These include my own bone or gum tissue; a freeze-dried human graft tissue from an accredited tissue bank; a synthetic bone graft or a soft tissue substitute; or processed animal tissues. Tetracycline or another antibiotic may be mixed with the graft. A “guided tissue regenerative” (GTR) membrane may also be used.

I HAVE CROSSED OUT ANY MATERIALS THAT ARE NOT ACCEPTABLE TO ME.

I realize that these rebuilding techniques may only be partially successful and may require a second corrective surgery to complete the treatment (additional fee to be charged).

Side effects of this surgery may include, but are not limited to: swelling; infection; discomfort; limited opening of the mouth for several days or weeks; parasthesia (numbness) of the jaw or gums, which may persist; gum recession (shrinkage); interference with speech; sensitivity to hot or cold for several days, weeks or months; food lodging between the teeth, requiring the use of cleaning devise, such as special brushes or floss; and unaesthetic exposure of crown (cap) margins and root surfaces.

I further understand that if, no treatment or limited non-surgical treatment is given; my present periodontal condition will probably worsen in time and result in tooth loss.

NO GUARANTEE, WARRRANTY, OR ASSURANCE HAS BEEN GIVEN TO ME THAT THE PROPOSED TREATMENT WILL BE SUCCESSFUL TO MY COMPLETE SATISFACTION. DUE TO INDIVIDUAL PATIENT DIFFERENCES, THERE IS A SMALL RISK OF FAILURE, RELAPSE, SELECTIVE RETREATMENT, OR WORSENING OF MY PRESENT CONDITION DESPITE THE BEST CARE, LOSS OF SUPPORTING TISSUES OR BONE WOULD OCCUR SOONER WITHOUT THE RECOMMENDED TREATMENT.

I understand that smoking, alcohol, high stress, and poor nutrition can impair the healing after periodontal surgery. I agree to limit these adverse factors and follow Doctor's post-operative and home care instruction.

I understand that long-tem success requires my continuing performance of effective personal plaque control (daily home care). In addition, I must receive professional periodontal maintenance every 2-4 months for periodontal cleaning and evaluation.

I consent to the taking of photographs and or x-rays of my oral and facial structures and their use for educational purposes. I understand that I will not be identified and any of these presentations.

Sign: _____ _____
(Signature of patient or guardian) (Date)

Witness: _____ _____
(Signature) (Date)

Doctor: _____ _____
(Signature) (Date)