**MAHNAZ ZANDI D.D.S. M.S.**
**2080 CENTURY PARK EAST STE. 1801**
**LOS ANGELES, CA. 90067**
**310-553-5754**

An explanation of your need for gingival graft surgery, the procedure care, its purpose, benefits, possible complications as well as alternatives to this proposed treatment were discussed with you at your consultation, and we obtained your verbal consent to undergo the treatment planned for you. Please read this document which repeats issues we discussed and provide the appropriate signature on the last page. Please ask us to clarify anything that you do not understand and answer any of your questions at any time.

# Patients Consent for Gingival Graft Surgery

**Explanation of Diagnosis:** I have been informed of the presence of significant gum recession our insufficient gum tissue in my mouth which may be adjacent to muscle attachment. I understand that it is important to have sufficient amount of firm gum tissue around teeth at the gumline to minimize further gum recession which may compromise tooth retention._____

**Explanation of Gingival Grafting:** I have been informed that the main purpose of gingival (gum) grafting is to create and adequate zone or band (width) of firm gum tissue to help further prevent gum recession. Graft surgery may also be performed to cover exposed roots. _____

**Recommended Treatment:** It has been recommended that gingival grafting be performed in areas of my mouth where I have gum recession. It has been explained that this a surgical procedure involving the removal of a thin strip of gum tissue from either the surface of my mouth alongside the upper teeth and transplanted (moved) over to the area of the gum recession or exposed root (s). I understand that some or all of the gum placed over the root may shrink back during healing and that proposed surgical attempt to cover the exposed root surface may not be completely successful. _____

**Risks Related to the Suggested Treatment:** Although a low risk procedure, risks related to gingival grafting might include post-operative bleeding, swelling, pain, infection, facial discoloration, temporary or on occasion permanent tooth sensitivity to hot or cold or sweets or acidic foods. A temporary or permanent numbing of the surgical areas may occur on rare occasion. Risks related to the local anesthetics 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 local anesthetics. _____

**Alternatives to Suggested Treatment:** I have the choice of not receiving any treatment to the area involved. It has been explained to me that doing nothing leaves the tooth open to sensitivity, microbiological insult and eventual and/or bone and or tooth loss.

**Consent to Unforeseen Conditions:** During surgery, unforeseen conditions may be discovered which call for a change from anticipated surgical plan. These may include but are4 not limited to extraction of hopeless teeth to improve healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material or the

use of material to guide (enhance) tissue regeneration or termination of the procedure prior to completion of all of the surgery originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor._____

**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 in treating recessions. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the potential of longer retention of my teeth by reducing the likelihood of further gum recession in the treated area (s) but due to individual patient difference certainty of success is not assured. Therefore, failure, relapse, selective re-treatment, or worsening of my present condition may occur. _____

**Compliance with Self-Care Instructions:** I understand that smoking and/or alcohol intake may adversely affect gum healing or compromised surgical success. I agree to follow instructions related to my own daily care of my mouth. I agree to attend appointments following my surgery as that healing may be monitored and reevaluated upon healing completion for future needs._____

**Use of Photos Film, Recording and X-rays of Me:** I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my face, my name or other identifying information or characteristics are revealed or disclosed._____

**Patient's Endorsement:** My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanation referred to or implied, and that after careful consideration, I give my consent for the performance of any and all procedures related to gingival graft surgery as presented to me during consultation and treatment plan presentation by the doctor or as described in this document._____

_____ _____

Patient's Signature (Signature of Parent or Authorized Representative ) Date

_____ _____

Signature of Doctor Date

_____ _____

Signature of Witness (Relationship to Patient) Date