



Consent Form: Periodontal Surgery

Periodontal surgery is performed in cases of periodontal disease in order to stop the progress of the disease. The surgery is normally performed under local anesthesia.

Name of patient: _____
Last Name First Name Father's Name I.D.

I declare and confirm that I received detailed verbal explanation from:

Dr. _____
Last name First Name

regarding the need to perform periodontal surgery in the upper jaw / lower jaw/ both jaws
(Hereinafter: the "Principal Treatment").

I was informed of the necessary treatment and of the possible alternative treatments under the circumstances of the case including conservative periodontal treatment, and that I had considered them before choosing the surgical treatment. I was informed that periodontal surgery can never restore the original condition of the gums.

I was also informed of the risks involved in avoiding treatment for periodontal disease, including loss of teeth, gum recession, bone loss, mobility of teeth, sensitivity to cold and heat, difficulty maintaining oral hygiene, recurrent infections and gum bleeding.

It was clarified to me that the success of periodontal treatment and/or control of the periodontal disease depend, among other things, on the preoperative severity of periodontal disease and on additional risk factors such as smoking, diabetes and alcohol consumption.

I was informed of the side effects of the Principal Treatment, including larger gap between the gums and the tooth crown, exposure of existing crown margins, teeth that may appear longer, sensitivity to cold and heat, swelling, pain and subcutaneous hematoma in the face and neck.

I was also informed of the possible risks and complications of the Principal Treatment including infection, limitation in mouth opening, teeth mobility up to a stage requiring their extraction, in addition, risk for neural injury manifested in loss of sensation up to a level of temporary or permanent loss of sensation in the gums and/or lip and/or tongue and/or chin and/or face. It was explained to me that the manner and duration of postoperative recovery of the bone and gums was individual and unpredictable and may take about two weeks. I was further explained that undergoing surgical treatment while using medications for the treatment of bone diseases such as osteoporosis, metastases, multiple myeloma, especially combined with steroid therapy, smoking and diabetes enhances the risk of chronic inflammation up to necrosis of the jaw bones.

In addition, I was informed and I understand the importance of cooperation and compliance with the instructions of the medical staff including, among other things: Maintaining strict oral hygiene, undergoing preventive periodontal treatment by a dental hygienist and/or by the dentist as frequently as required by them and attending for checkups.

I hereby give my consent to the Principal Treatment.

My consent is also given for local anesthesia, after I received explanations about the risks and complications of anesthesia including sensory injury to the lip and/or to the tongue and/or to the chin and/or to the face, subcutaneous bleeding, swelling and temporary limitation in mouth opening. Should it be decided to perform the Principal Treatment under general anesthesia or under intravenous sedation, the anesthetic technique would be explained to me by an anesthesiologist.

Date Patient's Signature

Name of Guardian (Relationship) Guardian's Signature
(When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

Name of Physician Signature License No.