Tyler Kim DDS & Tat Chiang DMD

EXPLANATION AND CONSENT TO PLANNED GUM SURGERY

Patients Name:_____ - Date:_____

Dr. Tyler Kim and Dr. Tat F. CHIANG (hereinafter referred to as *Doctor)* has examined me, in regard to certain dental conditions of which l am personally aware of and / or have otherwise been made aware. Based on Doctor's examination and the explanatory review of my dental complaints provided to me, and in particular the analysis and diagnosis of designate, to perform such periodontal surgery upon me as in Doctor's discretion and judgment may be advisable in my behalf.

The Doctor has fully informed me that the purpose of the planned surgery is to treat and correct, to extent possibly, my periodontal diseased mouth, gum tissues, teeth and jawbones.

I realize that unforeseen conditions may arise during the course of surgery. I understand that this would call for Doctor's exercise of judgment or for procedures, including extraction of teeth, which were not visualized and determined either during the course of discussions with me or during surgery. I hereby consent to such extractions or other procedures on my behalf**,** and I authorize the Doctor to do whatever is deemed most advisable in my behalf.

Doctor has explained to me in detail that there exists possible post-operative risks, may result from periodontal surgery, drugs, or anesthetics, These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum associated jaw joint muscle spasm, tooth sensitivity to hot, cold, sweet or acidic, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing and aspiration of foreign matter and other unforeseen risks. The exact duration of and complication cannot be determined, and they may be irreversible.

I also understand that if I do not pursue a course of treatment, my present periodontal condition will probably worsen with the passage of time, and that this may result in premature tooth loss.

It has been made clear to me that because of individual patient differences, there cannot be any guarantee or assurance that treatment proposed to me will be successful. I realize there exists a risk of failure and relapse or worsening of present conditions despite Doctor's best efforts and best care in my behalf.

I understand that long-term success requires my long-term continued cooperation of post operative oral care, daily plaque control (home care), periodic periodontal maintenance visits and no smoking.

Bone graft procedure patient - I understand that certified sterilized cadaver/cow bone is used for this procedure.

I consent to photographs of my oral and facial structure and their publication for educational and scientific purposes.

For patient who is on **Bisphosphonate** (*Fosamax, Alendronate, Didronel, Skelid, Actonel, Boniva, Aredia, Zometa, etc.*): I understand that periodontal treatment may cause osteonecrosis of the jaw and dental treatment may increase the risk.

CONSENT

I am aware that the practice of periodontal surgery and Dentistry is not an exact science, and I acknowledge that I have not been given or received any guarantees, as to the results to be obtained from the surgical treatment I am to receive.

_____ _____

Patient's or Legal Guardian Signature Date

_____ _____

Doctor's Signature Date

_____ _____

Witness's Signature Date