

I understand the purpose of a **Gingivectomy by Laser Procedures** is to eliminate or remove gum tissue to either improve the appearance of the smile, gain access to a tooth that has not erupted, remove excessive gingival tissue due to periodontal disease or removal of a lesion. I understand that this treatment will be performed with a CO2 Laser. Generally laser treatment results in improvement in the intended condition but occasionally the procedure will need to be repeated to get the desired outcome.

I understand that Periodontal Procedures (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. I agree to assume those risks and possible unsuccessful results associated with, but not limited to the following: (Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions, there are no promises or guarantees as to anticipated results.)

- 1. Response to Treatment:** Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process in which tissue response is a vital element will achieve the results desired by the attending dentist and hygienist as well as the patient.
- 2. Postoperative Patient Responsibility for Care:** With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment as instructed by the treating dentist and/or hygienist. Without the necessary follow-up care by the patient, the probability of unsatisfactory or unsuccessful results is greatly increased.
- 3. Eye Damage:** Injury of the eyes is possible if you look into the laser beam. We will provide eye protection that will prevent this but it must be in place at all times when the laser is in operation.
- 4. Bleeding During or After Treatment:** Laceration or tearing of the gums may occur which might require suturing. The gums may bleed as well during or after treatment. If bleeding seems excessive after treatment has been rendered, the treating dentist should be contacted.
- 5. Burns:** There is a risk of accidental injury by the laser energy which could cause permanent scarring; however, this is very unlikely as the laser energy is carefully metered and contained.
- 6. Pain or Burning/Itching sensation may occur for a few days after treatment.** A topical anesthetic and occasionally a local anesthetic can be used to help ease the discomfort.
- 7. Bleeding, Bruising, and Swelling:** Following a Gingivectomy procedure, there are occasions when bleeding may occur. Instructions as to how this may be controlled will be given to you. Redness, inflammation or swelling of the tissue will likely be noticed for the first few days. The tissue surrounding the sight of the procedure may feel "tight". Some bruising and/or swelling of the intraoral and facial tissues may occur. It is highly recommended that any application of excess heat to the treated area must be avoided for 2-3 days to minimize bleeding and promote healing. If extreme, it is your responsibility to contact this office.
- 8. Infection:** On occasion, postoperative infections(s) may occur. This may range from mild to severe in nature. Should you have any concerns related to this potential problem, this office should be contacted as soon as possible.
- 9. Tissue Pigment Changes:** Soft tissue color and texture changes may occur. At the junction of treated and untreated areas, a difference in color, texture, and/or thickness may appear. This condition cannot be predicted or controlled by the dentist and/or is associates.
- 10. Scarring:** The risk of scarring exists. It is variable and often related to genetic makeup. It can be minimized by carefully following appropriate aftercare instructions. This condition cannot be predicted or controlled by the dentist and/or is associates.

11. Gum Recession and Tooth Sensitivity: As a result of periodontal treatment or gingival (gum) surgery, gum tissues may shrink or recede exposing the edge or margins of crowns and bridges, creating an unaesthetic or unsightly appearance. Additionally, spaces may be created between the teeth that were not there previously. It may be necessary to replace pre-existing crown and bridgework as a result of shrinkage and recession. Additionally, root surfaces may be exposed which increase the sensitivity of the teeth and may also require additional procedures to alleviate.

12. Reaction to Medications or Anesthetics: Allergic reactions may exhibit themselves which may be of mild to very severe in nature relative to medications, materials, and/or anesthetics. It is the responsibility of the patient to fully inform the dentist or hygienist of any past allergic reactions.

13. Injury to the Nerves: There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which may occur is usually temporary, but in rare instances could be permanent.

I understand that it is my responsibility to notify Gunnerson Dental should any undue or unexpected problems occur or if I experience any problems relating to the treatment rendered or the services performed.

Informed Consent: I have been given the opportunity to ask any questions regarding the nature and purpose of **Periodontal and Gingivectomy Procedures** and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. I understand this is an elective procedure and the treatment is not reversible. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize this practice and/or their hygienists or associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications. I understand it is my responsibility to inform the doctor of ALL the medications I am currently taking as well as any allergies.

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to use Electronic Records and Signatures.: []

Relation to Patient:

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

I consent to use Electronic Records and Signatures.: []