AUTHORIZATION AND INFORMED CONSENT TO PERIODONTAL SURGERY

Patient:______________________________

This Authorization and Informed Consent to Periodontal Surgery is given to Charles J. Burliss, DMD, MScD, PC. It is given of my own free will after Dr. Burliss has first explained to me the nature of the proposed treatment and/or surgical procedures involved and foreseeable dental and medical risks involved as discussed below.

1. DIAGNOSIS

__Dr. Burliss has informed me (or name of patient if not signatory) that I suffer from the condition known as periodontitis. The diagnosis has been explained to me.

__Dr. Burliss has informed me (or name of patient if not signatory) of the need for dental extraction (s). The reasons have been explained to me.

__Dr. Burliss has advised me (or name of patient if not signatory) of the need for mucogingival surgery. The reasons have been explained to me.

2. PROCEDURE

I hereby authorize Dr. Burliss and whomever he may designate as his assistants to perform the following surgery:

__EXTRACTION (S)
__GINGIVAL FLAP
__MUCOGINGIVAL SURGERY
__OSSEOUS GRAFT
__OSSEOUS SURGERY

3. TREATMENT RISKS

Dr. Burliss has explained to me that there are certain inherent and potential risks in any treatment plan. For this specific treatment such post-operative risks include but are not limited to the following:

__Exposure of margins of crowns
__Food impaction
__Gum recession
__Infection
__Other
__Pain
__Phonetic interferences
__Swelling
__Temporary restricted mouth opening
__Thermal sensitivity
__Tooth mobility

4. 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 eradicating pockets, infection, or further bone loss or gum recession. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore, there exits the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

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5. CONSENT FOR UNFORSEEN CONDITIONS
During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. I therefore consent to the performance of such addition or alternative procedures as may be deemed necessary in the best judgment of Dr. Burliss.
6. COMPLIANCE WITH SELF-CARE INSTRUCTIONS
I understand that moderate to heavy smoking (5-10 cigarettes a day) and/or alcohol intake and inappropriate foods will affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth, to the use of prescribed medications and to the limitations in use of current removable partial/dentures or appliances. I agree to report for appointments as needed following my surgery so that healing may be monitored and Dr. Burliss can evaluate and report on the success of the surgery.
7. PHOTOGRAPHS
In furtherance of the profession of dentistry and the dental health of the public, I do hereby consent to photographs being taken of my oral and facial structures and subsequent publication solely for educational and scientific purposes.
8. MINOR'S CONSENT
I am executing this 'Authorization and Informed Consent to Periodontal Surgery' on behalf of ______________________. In doing so I have advised Dr. Burliss that I am the legal guardian.

I certify that I have read and fully understand the above 'Authorization and Informed Consent to Periodontal Surgery' form and the explanations referred to herein above. I further acknowledge that all blanks or statements requiring insertion or completion in this consent were filled in, and inapplicable matters, if any, were stricken before I signed.

Patient\LegalGuardian:________________________________Date:______________

Witness:____ Date:______________