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### CONSENT TO PERIODONTAL (GUM) SURGERY

I hereby authorize D. Brock Lynn, Jr., D.D.S., M.S. (herein called Doctor) to perform the operation of periodontal surgery upon \_\_\_\_\_

NAME OF PATIENT

Doctor has advised that diagnosis indicates I have a condition known as *Periodontitis (Periodontal Disease)*, which I understand to be an infection affecting my gums and the bone supporting my teeth.

I have been informed that the purpose of this operation is to surgically improve or correct my periodontally diseased gum tissue, teeth, and supporting jawbone.

I understand that if I desire, sedative drugs may be used to reduce my anxiety and discomfort by making me relaxed and sleepy. These drugs may also reduce my ability to remember events occurring on the day of the operation. I understand and agree that if sedative drugs are required before surgery I will not drive myself home following surgery, but will arrange to be driven and accompanied home. I agree not to operate a motor vehicle or hazardous machinery for at least 24 hours.

In the event that the removal of any teeth is deemed advisable by the Doctor due to conditions visualized and determined at the time of surgery, I hereby consent to such removal.

If any unforeseen conditions should arise during the course of the operation, calling the Doctor's judgment or for procedure in addition to or different from the now contemplated, such as synthetic bone grafting and /or G.T.R., I further request and authorize the Doctor to do whatever he may deem advisable.

Further, I have been informed that other possible alternative and/or supplemental methods of treatment exist to include but are not limited to: curettage (scraping of the gum linings), prophylaxis (cleaning) alone or in conjunction with curettage, root planning (smoothing), and/or occlusal adjustment (selective grinding of the teeth).

Post operative risks of the proposed surgery include, but are not limited to: swelling, infection, pain, restricted mouth opening for several days, weeks or longer, paresthesia (numbness) of the jaw, tongue or gum nerves which may persists for several weeks, months, or in remote instances permanently, gum recession (shrinking-teeth appear to be longer than before), temporary, or in rare instances, permanent interference with phonetics (speech sounds), clicking or pain in the temporomandibular joints (jaw joints), tooth sensitivity to hot or cold for days, weeks, or on occasion for several months, transient, or in instances permanent tooth mobility (looseness) in selected areas, food lodging between the

exposure of crown margin

I further understand that if no treatment is rendered, my present periodontal condition may worsen in time, which may result in premature tooth loss.

I know the practice of dentistry is not an exact science and that reputable Practitioners cannot guarantee results. No guarantee or warranty or assurance has been given to me by anyone that the proposed periodontal surgery will be successful to my complete satisfactions. Due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition to include the possible extraction of certain involved teeth despite the best of care. However, it is Doctor's opinion that therapy will be helpful and that any further loss of supporting tissue or bone would occur sooner without the recommended surgery.

I do understand that long-term success requires my long-term continued performance of mechanical plaque removal (daily home care) and my availability for periodic maintenance (cleaning and check-up) visits.

I (do) (do not) consent to photographs of my oral and facial structures and their publications for educational and scientific purposes.

I am executing this Authorization and informed Consent to periodontal surgery on behalf of \_\_\_\_\_ . I so doing, I have advised the Doctor that I am their legal guardian (or closest relative). As such I am authorized to execute this consent on his or her behalf.

I CERTIFY THAT I HAVE READ FULLY AND UNDERSTAND THE ABOVE CONSENT, AND THOSE ALL-INAPPLICABLE PARAGRAPHS, IF ANY WERE STRICKEN BEFORE I SIGNED. I UNDERSTAND THAT THE DOCTOR HAS MADE THE DIAGNOSIS OF PERIODONTITIS AND ADVISES ME TO HAVE THE OPERATION OF PERIODONTAL SURGERY PERFORMED.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Legal Guardian or Closest  
Relative

\_\_\_\_\_  
WITNESS