Clifton E. Nakatani DDS MSD
Practice Limited to Periodontics and Implants

CONSENT FOR PERIODONTAL FLAP SURGERY

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of periodontal disease in my mouth and that this involves the weakening of support to my teeth by first producing a separation of the gum from the teeth (pockets). This allows for the greater accumulation of bacteria under the gum in hard to clean areas and that this can result in my bodies defense reactions or infection resulting in the erosion or loss of bone supporting the roots of my teeth.

PURPOSE OF PERIODONTAL FLAP SURGERY: I have been informed that the purpose of this procedure is to allow access for the cleaning of the roots of teeth and the lining of the gum as well as to treat irregularities to the jaw bone surface so that when the gum is replaced about the teeth, it will allow for the reduction of pockets, infection, and inflammation. The reduction of pockets should enhance the ease and effectiveness of my personal oral hygiene and of the ability of professionals to better clean my teeth of tartar and bacteria. The reduction of infection and inflammation should minimize further loss of bone supporting my teeth and thus aid in the longer retention of my teeth in the operated area(s).

SUGGESTED TREATMENT: I have been informed that my suggestive treatment should include periodontal flap surgery.

ALTERNATIVES TO THE SUGGESTED TREATMENT: These may include: (1) no treatment with the expectation of the advancement of my condition resulting in the possible premature loss of teeth; (2) extraction of teeth involved with periodontal disease; (3) attempts to further reduce bacteria and tartar under the gumline by non-surgical scraping of tooth roots and lining of the gum (root planning and curettage) with the expectation that this will not fully eliminate deep bacteria and tartar, result in only a partial and temporary reduction of inflammation and infection, will not reduce gum pockets, and will require more frequent professional care and may result in the worsening of my condition and the premature loss of teeth.

RISKS RELATED TO THE SUGGESTED TREATMENT: Risks related to periodontal flap surgery might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet and/or acidic foods, shrinkage of gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Risks related to the anesthetics might include, but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

RISKS ASSOCIATED WITH NON-TREATMENT: I understand that if no treatment is performed, either that which has been proposed or any other reasonable alternative treatment, that such a decision is my sole responsibility. I acknowledge that risks related to my non-acceptance of treatment for my problem have been explained to me and include, but are not limited to, dissatisfaction with or failure of other forms of tooth replacements, further deterioration of jaw bone, further gum recession, problems with my bite including pain, spasm, headaches, or problems with my jaw joints or associated musculature.

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, infections, or further bone loss or gum recession. It is anticipated (hoped) 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, but due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective re-treatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement despite the best of care.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include, but not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material or the material to guide (enhance) tissue regeneration or termination of the procedure prior to completion of all of the surgery originally outlined. I, therefore, consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Nakatani.

BLOOD CONCENTRATES: I give my consent to use my own blood in the surgical procedure utilizing my blood concentrate. The amount of blood drawn for this procedure is approximately 20-60 cc's.

INITIAL _____

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SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to the procedure. I give consent that my records may be used for educational use in lectures or publications provided my identity is NOT revealed.

ANESTHESIA:

☒ Local anesthesia will be used.

☐ Local anesthesia with oral anti-anxiety medication. **If you take this medication, YOU CANNOT DRIVE. You will need a driver to stay in our office for the duration of the surgical visit.**

ANESTHESIA RISKS include discomfort, swelling, bruising, infection, prolonged numbness, and/or an allergic reaction.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I agree to diligently comply with any and all pre-operative and post-operative instructions given to me. I understand that if I need to and don't return for my follow-up visits, my condition may get to a point where I might need more care or more surgery. I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my treatment. It is my responsibility to timely seek attention should any undue circumstances occur post-operatively. I agree to report for post-operative care appointments following my treatment so that my healing may be monitored and so that Dr. Nakatani can evaluate and report on the outcome of my treatment upon completion of healing.

BISPHOSPHONATE DRUG RISKS: For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone.

SECOND OPINION: If any significant doubt or questionable understanding persists after receiving explanations and/or reading this document, I have been encouraged to seek another opinion from a dentist knowledgeable in the area of periodontal dentistry prior to completing my deliberation and decision.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of this procedure and have received answers to my satisfaction. I recognize that it is my responsibility to fully inform Dr. Nakatani of the condition of my health and any and all problems thereto. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and/or any results from the treatment rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, (1) certifies that I have read and understand the entirety of this document and (2) I am freely giving my consent to authorize Dr. Nakatani and/or all associates involved in rendering any services he/she deems necessary and advisable to treatment of my dental conditions, including any anesthetic agents and medications.

X _____

Name of Patient (Please Print)

X _____ X _____

Signature of Patient or Legal Guardian Date

As a part of this consent agreement, I give my personal pledge, as a healthcare professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.

Clifton E. Nakatani DDS MSD INC. _____

Witness