DISTAL WEDGE
AUTHORIZATION AND CONSENT TO PERIODONTAL SURGERY

1. It has been explained to me that I have periodontal (gum) disease or other gum problems and that I require the following procedure(s): the use of local anaesthetic (freezing), reflecting the gums enough so that the roots of the teeth and surrounding tissue can be thoroughly cleaned of infecting agents, smoothing and reshaping the adjacent bone to its normal shape, grafts of synthetic and/or sterilized human or animal donor bone, use of sutures (stitches), use of a dressing or covering of the site.

2. I have also been informed that an alternate procedure which, though not the recommended therapy, may also benefit me to some extent is: thorough cleaning of the root surfaces (scaling and root planing) using local anaesthetic (freezing), but without gaining access by reflecting the gums.

3. I understand that risks of the recommended treatment include, but are not necessarily limited to: (a) allergic or other reactions to the local anaesthetic or other medications used, (b) swelling and/or infection, (c) pain and/or thermal sensitivity, (d) exposure of root surfaces (gum recession) and/or margins of crowns (caps), (e) increased tooth mobility, (f) temporary restricted mouth opening, (g) numbness of jaw or gum nerves.

4. I understand if no treatment is rendered the risks to my dental health include, but are not limited to: (a) further deepening of periodontal (gum) pockets, (b) halitosis (bad breath), (c) gum abscesses (boils), (d) loosening or drifting (movement) of teeth, (e) uncontrolled gum recession, (f) premature loss of teeth.

5. No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth. However, it is the doctor's opinion that therapy will be helpful, and that any further loss of supporting tissue or bone would occur sooner without the recommended treatment.

6. It has also been explained to me that in order for me to achieve long term benefits from my treatment, it is required that I perform effective daily oral hygiene (plaque control procedures) and regularly attend for cleanings (maintenance care).

7. I consent to photography, video recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications, provided my identity is not revealed.
8. I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SATISFACTORILY SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT BEFORE HEREBY SIGNING.