INFORMED CONSENT FOR PERIODONTAL FLAP SURGERY

This is my consent for Dr. Bijan Afar and his employees, agents and other auxiliary personnel to perform Periodontal (gum) surgery (including _____) as Deemed necessary to treat me. I have been advised of alternatives to surgical therapy, including maintenance therapy and the risks and benefits of both. I also agree to the use of local anesthesia. Nitrous oxide-oxygen sedation may be used for anxiety control at my request barring any medical contraindications.

I have been informed and understand that occasionally there are complications of periodontal surgical procedures, drugs and anesthesia. These include, but are not limited to root exposure, root sensitivity to hot, cold and sweets; pain, infection, swelling, bleeding, discoloration; numbness, tingling and trauma to the tongue and lips; change in the bite; loosening of the teeth; injury to other tissue; nausea and vomiting; adverse reactions to prescribed medications and anesthetics including allergic reactions; delayed healing and sinus complications.

Medications, prescription drugs and anesthetics may cause drowsiness and lack of awareness and coordination. This effect may be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle or hazardous device until fully recovered from the effects of these drugs and to avoid the use of alcohol when using such drugs. This includes pre-operative relaxant medicine given to me prior to the procedure and narcotic drugs prescribed for me after periodontal surgery.

I understand that I will receive postoperative instructions, that I will be given an appointment date to return, and that I may call this office at any time if questions or problems arise. It has been explained to me and I understand there is no warranty or guarantee as any result and that there is no cure to periodontal disease; rather the ultimate success of treatment depends largely on my ability to thoroughly remove dental plaques from the teeth and to follow through with prescribed periodontal maintenance.

I have been advised of my right to consult with another periodontist of my choosing to obtain a second, independent evaluation of dental conditions diagnosed and /or the recommended treatment. I have further been advised of my right to seek independent guidance and counsel from any other person or persons of my choosing. I have either done so or have independently determined that the same is not necessary prior to consenting to this procedure.

PRINT NAME_____

PATIENT SIGNATURE_____

DOCTOR'S SIGNATURE_____

DATE_____