



**Informed Consent for Gingivectomy**

Patient's First Name \*

Patient's Last Name \*

A type of surgery used to remove excessive tissue or reduce pockets. It involves not only removal of the tissue, but scaling and root planning of the affected teeth. This procedure is performed with local anesthesia. All dental treatments have an associated risk. Periodontal surgery of any type may result in bleeding, swelling, bruising, pain, infection, sore jaws, recession, tooth sensitivity to hot and cold, caries exposure, etc. I understand that every person responds to treatment differently. Therefore, it is impossible for the doctor to predict how long the healing period may require or if time away from normal routines may be necessary. I understand that smoking and poor oral hygiene may significantly interfere with healing and cause disease reoccurrence. I understand if no treatment is rendered or if active treatment is interrupted or discontinued, my periodontal condition would likely continue and worsen. This may result in pain, swelling, bleeding, infection, recession, mobility, decay, staining, bone loss, and tooth loss. In the case of a gingivectomy, a second procedure may be required to ensure good symmetry and esthetics, depending on how the tissue heals. I have been advised of my alternatives to this treatment and understand what has been proposed thoroughly. I confirm with my signature that: My Dentist has discussed the above information with me. I have had the chance to ask questions. All of my questions have been answered to my satisfaction. I do hereby consent to the treatment described in this form.

\* Date \*

Witness First Name

Witness Last Name

Date \*