



## CONSENT FOR GINGIVAL GRAFTING SURGERY

Treatment tooth/teeth #(s): \_\_\_\_\_

I hereby authorize Dr. Tuan Nhu to perform gingival grafting treatment. I understand that Dr. Nhu is not a specialist (periodontist), and I am declining immediate referral to a specialist at this time. I further understand that Dr. Nhu may cease treatment and make a referral to a periodontist should any unanticipated difficulty or untoward event occur during or after treatment at my additional expense.

### ***Recommended Treatment.***

In order to treat this condition, I have been recommended gingival grafting procedures. I understand that a local anesthetic will be administered and sedation may be utilized to me as part of the treatment. Transplanted tissue will be placed to partially or completely cover the tooth root surface exposed by recession. The transplanted tissue is AlloDerm, an acellular dermal matrix from a tissue bank. Occasionally palatal tissue may be used.

### ***Expected Benefits.***

The primary purpose of gingival grafting is to increase the thickness of gum tissue to reduce the likelihood of further gum recession. Other purposes for this procedure are to cover exposed root surfaces, to enhance the appearance of the teeth and gum line, and to prevent or treat sensitivity or root decay.

### ***Principal Risks and Complications.***

I understand that occasionally the surgical outcome does not meet expectations. If a graft is placed to cover the tooth root surface exposed by the recession, the tissue placed over the root may shrink back during healing. If this occurs, the coverage of the exposed root surface may not be complete. Occasionally, a secondary procedure may be performed if additional root coverage is needed.

I understand that complications may result from gingival grafting or from anesthetics. These complications include, but are not limited to:

1. Bleeding, swelling, and pain
2. Facial discoloration
3. Post-surgical infection
4. Transient or on occasion permanent tooth sensitivity to hot, cold, sweet, or acidic foods.

Less common side effects include, but are not limited to:

1. Numbness of the jaw, lip, tongue, teeth, chin or gum
2. Jaw joint injuries or associated muscle spasm
3. Transient but on occasion permanent increased tooth looseness
4. Restricted ability to open the mouth for several days or weeks
5. Impact on speech
6. Allergic reactions
7. Accidental swallowing of foreign matter.

The exact duration of any complications cannot be determined, and they may be irreversible.



There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of gingival grafting can be affected by:

1. Trauma to the healing graft
2. Smoking
3. Medical conditions
4. Clenching and grinding of teeth
5. Dietary and nutritional problems
6. Alcohol consumption
7. Medications that I may be taking.

To my knowledge, I have reported to my dentist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way be related to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

***Alternatives to Suggested Treatment.***

My dentist has explained alternative treatments for my gum recession. These include no treatment, continued monitoring for progressive recession, and modification of technique for brushing my teeth.

***Necessary Follow-up Care and Self-Care.***

I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. I further understand that long-term success requires my long-term continued performance of daily plaque removal and my return for periodic professional maintenance therapy.

***No Warranty or Guarantee.***

I know the practice of dentistry is not an exact science and that reputable practitioners cannot guarantee results. I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a dentist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, despite the best of care.

***Publication of Records.***

I authorize photos, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry or dental insurance documentation. My identity will not be revealed to the general public, however, without my permission.



GERMANTOWN  
DENTAL VILLAGE

**Tuan M. Nhu, DDS**

19330 Liberty Mill Road, Germantown, MD 20874  
Email: drnhu@germantowndentalvillage.com  
301-428-3211

I have been fully informed of the nature of gingival grafting surgery, the procedure to be utilized, the risks and benefits of such surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask my questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of gingival grafting surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to my performance of such additional or alternative procedures as may be deemed necessary in the best judgement of my periodontist.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.**

Patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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