PATIENT: ______________________________

DATE: ______________________________

GUM CONTOURING INFORMED CONSENT

I have been informed that I require gum contouring surgery on the following teeth:

UPPER RIGHT	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	UPPER LEFT
LOWER RIGHT	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	LOWER LEFT

PURPOSE OF THE TREATMENT:

Gum recontouring surgery improves appearance and function. Soft tissue is either removed, or repositioned.

The surgical procedure may last from fifteen to sixty (15-60) minutes. Home care instructions and required prescriptions will be provided after the surgery. I will be seen in the office in one week to check the surgical site, and to be shown how to care for the site. It may take five to seven (5-7) days for my mouth to feel comfortable, and another two to four (2-4) weeks for the tissue around the site to heal completely.

BENEFITS OF THE TREATMENT:

Gingival appearance and function is improved.

RISKS OF THE TREATMENT:

Despite excellent skill and care, it is possible for complications to arise. The tissue in the surrounding area will be sensitive and healing may be delayed without proper care and oral hygiene. Infection may also result.

If the final appearance is not ideal, touch-up contouring may be necessary.

Gums or tissues involved in the anaesthetic injection may be sore for several days following treatment. Swelling of the tissues around the injection site is possible and can be treated by applying pressure and cold (ie. ice packs) the day of treatment to the area of swelling for a minimum of 1-2 minutes. In addition, if freezing involves the lower jaws, there may be difficulty opening the jaw for the first few days. The soreness and stiffness will dissipate with time but warm salt water rinses or moist heat on the side of treatment will facilitate healing. Transient facial paralysis is a rare possibility upon anaesthetic injection, but it will almost always resolve itself without any future consequences.

ALTERNATIVES TO THE TREATMENT:

In order to treat malpositioned, or otherwise unsatisfactory gum tissue, there are no other alternatives.
I have had the purpose, benefits, reasonable risks and alternatives, if any, to the procedure(s) explained to

me. I have carefully read and understood all available explanatory material. I have been given the opportunity to ask questions.

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment.

I consent to the administration of such local anaesthesia and/or medication as is required for the aforementioned dental treatment.

I consent to the taking of photographs throughout the entire treatment procedure. Should these photographs be deemed by Dr. Bruno Paliani to benefit dental research, science, or education, I consent to their publication and republication, either separately or together, in professional journals or dental books or used for any other purpose which Dr. Bruno Paliani may deem proper in the interest of dental education, knowledge or research.

The dental fees of the procedure have been outlined clearly and I agree to comply with the office's payment policy.

PROFESSIONAL FEE ______________________

LAB FEE (approx.) ______________________

TOTAL FEE (approx.) ______________________

Dated at London, Ontario, this day of ______________________

SIGNED: ______________________
PATIENT

WITNESS: SIGNED: ______________________
Parent, Guardian or Nearest Kin if patient
is under the age of 18