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 Olga Byakina, D.D.S., M.S.*
 *Board Certified Periodontist and
 Dental Implant Surgeon

Periodontal Associates

OF MEMPHIS

Partners Emeritus
 James R. Ross, D.D.S., M.S.*
 Preston D. Miller, Jr., D.D.S.
 Roger D. Craddock, D.D.S.

Periodontal, Laser and Dental Implant Therapy

6268 Poplar Avenue · Memphis, TN 38119 · phone 901.761.3770 · fax 901.761.3775

www.PerioMem.com · Info@PerioMem.com

PATIENT'S NAME: _____

DATE: _____

REQUEST AND CONSENT FOR TREATMENT

An explanation of your diagnosis and problem list as well as suggested treatment was discussed with you at your examination/ consultation. We also discussed benefits of treatment, alternative treatment options, possible risks and complications, unforeseen complications, as well as compliance with necessary follow up care. We obtained your verbal consent to undergo the below procedure(s). This form should be filled out and reviewed by one of our doctors and team members. Please read this document (8 pages) which restates issues we discussed and provide the appropriate signature on the last page. If you like, please visit our website, www.PerioMem.com, for more information on the suggested treatment to resolve your problems. Also please ask for clarification of anything you do not understand.

DIAGNOSIS & PROBLEM LIST: We have diagnosed you with:

- Periodontal Disease Bite Trauma Abscess Missing Tooth/ Teeth Recession/ Insufficient Gum Tissue
 Gummy Smile Frenal Pull/ Involvement Orthodontic Problems Gum Hyperplasia
 Dark Gums Abnormal Tissue Unknown Condition
 Non-Salvageable Cracked/ Broken/ Decayed/ Short Tooth Salvageable Cracked/ Broken/ Decayed/ Short Tooth
 Other _____

SUGGESTED TREATMENT TO RESOLVE YOUR PROBLEM(S)

- Conventional Periodontal Surgery LANAP (Laser Periodontal Surgery) Scaling and Root Planing
 Root Amputation Hemisection Bite Adjustment Bite Guard Tooth Splinting
 Laser Gingivectomy Laser Lightening of Dark Gums Soft Tissue Gum Graft(s) Frenectomy
 Functional Crown Lengthening Esthetic Crown Lengthening "Gum Lift" Lip Travel Reduction
 Orthodontic Uncover Wilckodontics Temporary Anchorage Device (TADs)
 Bone Graft(s) Dental Implant(s) Biopsy
 Sedation - Nitrous (Laughing Gas), Oral (Pill) Sedation, IV Conscious Sedation (listed on separate consent form)
 Exploratory Procedure Other _____
 Extraction(s)(listed below) _____

Upper Right		A	B	C	D	E	F	G	H	I	J		Upper Left			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Lower Right				T	S	R	Q	P	O	N	M	L	K			Lower Left

DIAGNOSIS DESCRIPTION, PURPOSE AND BENEFIT OF RECOMMENDED TREATMENT, TREATMENT DESCRIPTION & ALTERNATIVE TREATMENT(S):

The following pages describe your diagnosis and problem(s) with the purpose and expected benefits of your treatment(s). Note, only the diagnosis and recommended treatment(s) that you are having applies to your situation. My periodontist and team have explained the alternative treatment(s) to resolve my problem(s). One of those options includes no treatment with the expectation of possible advancement of my condition resulting in a greater risk of complications including but not limited to bone loss, pain, infection on adjacent teeth and eventual tooth/teeth loss. Specific alternatives for different treatments we offer in our office are listed below. I understand sedation may be utilized and that a local anesthetic (numbing) will be administered to me as part of the treatment(s). Necessary follow up care and compliance with self care instructions are paramount to the success of treatment. Again, no treatment is always an option.



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PERIODONTAL DISEASE is an infection and inflammatory reaction in the gums and bone around your teeth. I understand that periodontal disease weakens support of my teeth by separating the gum from my teeth and possibly destroying bone that supports the tooth roots. The pockets caused by this separation allow for greater accumulation of bacteria under the gum in hard to clean areas and can result in further erosion or loss of bone and gum supporting the roots of my teeth. The purpose of periodontal therapy is to eliminate or substantially reduce diseased gum pockets and to restore my gum and bone to the extent possible to help control or prevent future gum and bone loss. Periodontal treatment is intended to help me keep my teeth in the treated areas and to allow access for me to clean more effectively. It should enable professionals to better clean my teeth as well. **Treatment for periodontal disease might include;** (1) LASER ASSISTED NEW ATTACHMENT PROCEDURE(LANAP)(LASER GUM SURGERY) reduces periodontal gum pocket depth by helping the periodontist have improved visualization of the laser-detached gum pocket soft tissue linings to aid scaling and root planing for removal of tartar (calculus) deposits (root cleaning). LANAP also promotes growth of new bone and/or reattachment of the laser treated gum tissues to the roots. Laser Gum Surgery treatments are generally less painful than flap surgical procedures and in the doctors' opinion have greater predictability for reattachment of gum tissue and bone growth. Thus, LANAP helps promote long term periodontal health. (2) Bite Trauma may also be treated. (3) CONVENTIONAL PERIODONTAL SURGERY (FLAP SURGERY)(OSSEOUS SURGERY) involves surgically cutting my gum tissues. After the gums are flapped and surgically lifted away from my teeth, the underlying diseased gum tissue is scooped out, teeth roots scraped, diseased bone trimmed and/or (4)Bone Grafted, a membrane may be placed, antibiotics and other substances may be applied to the roots of my teeth, the flap of gum tissue sutured closed, and a bandage may be placed around the teeth. Conventional Periodontal Surgery may be combined with Functional and/ or Esthetic Crown Lengthening. (5) DISTAL WEDGE (DISTAL GINGIVECTOMY) is used to remove tissue on the back (distal) of a tooth. (6) LASER GINGIVECTOMY FOR PERIODONTAL DISEASE FOR PERIODONTAL DISEASE and/ or Gum Hyperplasia (Overgrowth) is used to remove excess infected gum and help decrease pocket depth to aid in cleaning. It may also be used to improve the appearance of teeth and in orthodontics. (7) ROOT AMPUTATION/ HEMISECTION is removal of an infection or cracked tooth root(s) to save a tooth. If the tooth has not had a root canal it may require one. Alternatives to Root Amputation or Hemisection include tooth/ teeth removal (extraction) with or without tooth replacement possibly with a dental implant(s).

(8)NON-SURGICAL PERIODONTAL SCALING AND ROOT PLANING - After local anesthetic injections of my gums, root surfaces are scraped and deep cleaned (planed) to remove bacterial plaque containing tartar (calculus) deposits on my teeth roots. In general scaling and root planing is best for pockets up to 5 mm. For deeper pockets, other surgical treatments are more successful. Alternatives to surgical and laser periodontal treatment include Non -Surgical periodontal scaling and root planing (scraping of tooth roots and lining the gum) with or without antibiotics in an attempt to reduce further bacteria and tartar. In deeper pockets, scaling and root planing may not reduce pockets and may require more frequent professional care and time commitment and may not arrest the worsening of my condition and result in the premature loss of teeth including the problems listed in no treatment above. If left untreated, periodontal disease can cause me to lose my teeth and can have adverse consequences on my health.

BITE TRAUMA occurs when teeth are hitting too hard when chewing. This can encourage tooth breakage, tooth mobility and bone loss. Bite therapy with a Bite Guard, Bite Adjustment, and/ or Tooth Splinting helps to prevent damage from bite trauma. Alternatives to Bite Treatment include extraction(s) with or without tooth/ teeth replacement and no treatment.



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ABSCESSSES can be caused by various sources; periodontal disease, root canal (endodontic) disease, cracked roots, etc. These may be treated individually or with combined treatment - periodontal treatment, root canal, extraction with or without tooth replacement, etc. No treatment is also an alternative with possible further problems listed in no treatment above.

DENTAL IMPLANT(S) provide support for an artificial tooth/ teeth with a fixed (non-removable) crown or bridge or removable denture or bridge. I am aware that the type of implant to be used is one which is placed into the jaw bone; that this is sometimes placed by first reflecting a flap of gum, preparing a site in the bone, inserting the implant into the bone, and possibly covering the bone and implant with the gum flap. I understand that multiple surgeries maybe necessary: one to insert the dental implant(s) as described above, and maybe one to uncover the top of the implant(s) so that it is exposed and can be used for attachment of a tooth, bridge, partial or denture. I also understand that sometimes it is beneficial to add gum tissue (Gum Graft) to the implant site either prior to implant placement or after the implant(s) has healed. Additionally bone may be added by Bone Grafting per that section.

Alternatives to dental implants: Reasonable alternatives (crowns, partials, bridges, and/ or dentures) to implants have been explained to me. I have tried or considered these methods but desire dental implant(s) to help secure and replace my Missing Tooth/Teeth with a fixed crown or bridge or removable partial or denture by my referring or general dentist.

BONE GRAFTING(Ridge Preservation)(Sinus Lift)(Osteotome Lift)(Ridge Expansion)(Ridge Augmentation); adds bone where it is deficient to support teeth, dental implants, and enhance jaw bone. I understand that sometimes teeth or dental implant(s) are covered with a bone graft material and/ or a membrane [Guided Tissue Regeneration (GTR)] to further enhance healing and that this may necessitate an additional procedure to remove the membrane. These materials may include my own bone, synthetic bone substitute, or sterilized bone obtained from tissue banks (allograft). I also understand that if I have inadequate bone for implant placement, surgery to graft bone to correct the deficiency may be necessary before implant placement. Alternatives to bone grafting include no treatment with possible further problems listed in no treatment above.

SOFT TISSUE "GUM" GRAFTING (Connective Tissue Grafting) treats Gum Recession/Inadequate or Insufficient Gum Tissue by adding your gum tissue (from the palate or third molar area) or an allograft (sterilized donor tissue) around a tooth/ teeth, around dental implant(s), under a bridge, etc. The goal is to cover the root as much as possible and/ or to increase the thickness of gum to prevent further gum and bone loss and thus tooth loss. A Frenal Pull may be removed during a soft tissue graft. Alternatives to Soft Tissue Grafting (Recession): My periodontist has explained alternative treatments for my gum recession and how to modify my brushing techniques to prevent further recession. I understand an alternative to grafting of the gum or bone tissue is to do nothing which may result in further problems in my situation as listed in no treatment above.

FUNCTIONAL CROWN LENGTHENING (Crown Extension) contours the gum and bone around a tooth to save a Cracked/ Broken/ Decayed/ Short tooth/ teeth with a restoration (filling, crown, or bridge). This procedure improves the gum and bone health around a tooth, helps hold the restoration on the tooth, and/ or helps seal a restoration to a tooth to prevent bacterial leakage under a restoration. In may be used in combination with esthetic crown lengthening. Alternatives to Functional Crown Lengthening include no treatment with advancement of you problem including tooth loss mentioned above.



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ESTHETIC CROWN LENGTHENING "GUM LIFT" (Crown Extension) is used to create the correct contour of the gum around the teeth. This involves sculpting and removing excess gum and bone to improve the appearance of a short appearing tooth/ teeth and/ or to treat a "Gummy Smile" (extra gum that is seen when smiling). It may be used in combination with Functional Crown Lengthening.

Alternatives to Esthetic Crown Lengthening include no treatment with continued problems as listed above.

FRENECTOMY: is removal of excess tissue between teeth to allow the space between teeth to be closed (Orthodontic Problem) and/ or to prevent a Frenal Pull from causing Gum Recession. I understand an alternative to removal of the gum or bone tissue is to do nothing which may result in further problems in my situation as listed in no treatment above.

LASER GINGIVECTOMY FOR ESTHETICS is completed to aid in appearance of teeth and to help with orthodontic tooth movement (Orthodontic Problems). It may also be used to treat gum disease. Alternatives include no treatment.

LASER LIGHTENING OF DARK GUMS is used to remove the pigmentation in the Dark Gums with a laser and makes the gums lighter or pink. Sometimes esthetic crown lengthening may be completed first and then the dark gums removed. Alternatives include no treatment.

LIP TRAVEL REDUCTION PROCEDURE (Reverse Frenectomy) is used to treat a Gummy Smile by preventing excess movement of a hyper-mobile lip. Sometimes esthetic crown lengthening may be completed first and then lip travel reduction. Alternatives may include Orthognathic (Jaw Breaking) Surgery to position the jaw into a new position, Wilckodontics, or no treatment.

Temporary Anchorage Devices (TADs) solve Orthodontic Problems by helping move teeth into their desired position. TADs allow teeth to be moved faster and into positions not previously possible with orthodontics. One or more TADs are placed in the jaw bone and used during tooth movement and then removed. TADs may be used in conjunction with Wilckodontics. Alternatives include Conventional Orthodontics without TADs and no treatment.

Orthodontic Uncovery (surgical tooth uncover) is used uncover an impacted tooth/ teeth in order to allow placement of orthodontic appliances and help the tooth/ teeth move into their proper position. Wilckodontics and/ or TADs may or may not be used to help in tooth movement. Alternatives include extraction with or without tooth replacement possibly with a dental implant or leaving a tooth in place (no treatment).

Wilckodontics (Periodontal Accelerated Osteogenic Orthodontics) helps teeth move faster into their desired position. Bone Grafting may be used with Wilckodontics to add bone where it is needed to help support teeth and prevent periodontal problems (recession, bone loss, furcation invasion) and solve Orthodontic Problems. This procedure may be used around a specifically selected tooth/ teeth or all the teeth in the mouth. Orthodontic treatment typically begins prior to Wilckodontics. Alternatives may include Orthognathic (Jaw Breaking) Surgery to position the jaw into a new position, Conventional Orthodontics without Wilckodontics, and no treatment.



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Tooth Extraction(s) involves surgical or non-surgical removal of a tooth/ teeth. This would involve removal of a Non-Salvageable Cracked/ Broken/ Decayed/ Short or Unusable Tooth/Teeth or Abscessed tooth. The tooth/ teeth might be replaced and this replacement might include dental implant(s). Bone Grafting may be completed during tooth/ teeth removal. Alternatives to extraction might include periodontal treatment for periodontal disease, endodontic (root canal) treatment, and/ or crown lengthening as well as no treatment with possible advancement of problems as listed above.

Exploratory Procedure(s) are used when we have an Unknown Condition and are used to surgically determine what is wrong. During this procedure we may save a tooth/ teeth with Periodontal Surgery, LANAP, Root Hemisection or Root Amputation, Crown Lengthening to allow restoration, place a filling in a hole in the tooth, or result in Tooth Removal/ Extraction if the tooth is found to be Non-Salvageable Cracked/ Broken/ Decayed/ Short. With tooth removal, a Bone Graft may be placed to regrow bone and/ or a Dental Implant(s) placed now or later. Alternatives to an exploratory procedure are one of more of the above treatments or no treatment with possible further problems.

Biopsy is removal of Abnormal Tissue. This is a procedure in which a portion (incisional) or the entire the lesion (excisional) will be removed. A laser may be used with or without sutures. The expected result of this procedure is to adequately diagnose the lesion type. I understand the performance of diagnostic studies relating to my biopsy will be performed and billed by other medical/dental professionals. If my medical or dental policy requires a specific laboratory for diagnosis, I understand it is my responsibility to determine this prior to the biopsy procedure(s). Alternatives to biopsy include no treatment and monitoring the situation with continued problems listed above under no treatment. This may also result in non-cancerous lesion(s) developing into cancer and/or a cancerous lesions spreading (metastasizing) and getting worse.

POSSIBLE RISKS AND COMPLICATIONS RELATED TO SUGGESTED TREATMENT(S):

We attempt the best treatment possible and try to discuss the most frequent risks and complications with patients. This form may outline additional risks. Some risks are higher with certain procedures and in different areas of the mouth. In general, treatment success is high and risk and complications are low. However, there is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that a small number of patients do not respond successfully to treatment. I understand that there may be a need for a additional procedures if the initial results are not satisfactory. In addition, the success of procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, non-compliance with instructions, my treatment decision, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my Periodontist all my medical conditions as well as any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this procedure. I understand that my diligence in providing the personal daily care recommended by my Periodontist and taking all medications as prescribed are important to the ultimate success of the procedure(s). Taking narcotics (opioids) can cause addiction and problems with women who are pregnant or nursing, including adverse effects to the baby. Acetaminophen (Tylenol) and Ibuprofen (Advil) are non-opioid alternatives to narcotics we may prescribe. Ibuprofen may also have adverse effects on the baby.



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General Risks Related to Surgery are low and include, but are not limited to, post-surgical infection, bleeding, swelling, pain, facial discoloring (bruising), perforation of the upper jaw sinus or nasal cavity during the surgery, transient but on occasion permanent numbness of the lip, tongue, teeth, gum, face, or chin, jaw joint injuries or associated muscle spasms, bone fractures, jaw fractures, and slow healing, cracking of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

Anesthetic Risks include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain, inflammation, soreness and/or discoloration or blockage along a vein at the injection site. If using sedation, a separate consent form must be reviewed and signed.

Dental Implant Risks include, but are not limited to, unsuccessful union of the dental implant(s) to the jaw bone, and/or stress metal fracture of the dental implant(s).

Periodontal Treatment Risks are rare. In a small number of cases, periodontally involved teeth may require retreatment and/ or eventually may be lost. Periodontal surgery may not be successful in preserving function or appearance. Because each patient's condition is unique, long-term success may not occur. I understand that complications may result from the periodontal surgery, drugs, or anesthetics. Temporary but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the swollen, infected gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Filling, veneer, crown or bridge margins may become exposed.

Tooth Removal/ Extraction Risks might also include fracture of the tooth/teeth during surgery, retention of part of a root or roots, dislodgement of a tooth or part of a tooth into the upper jaw sinus, swallowing of a tooth or fragments of a tooth, aspiration of material, sensitivity to hot or cold or sweets or acidic foods, or shrinkage of the gum upon healing. Fractures to adjacent teeth, fillings, bridges, partials, crowns, and/ or veneers are possible which may require replacement.

Soft Tissue Graft (Gum Graft) Risks I understand when a gum graft is placed so as to cover the tooth root surface exposed by the recession, the gum may shrink back during the healing. In such a case, the attempt to cover the exposed root surface may not be completely successful. Indeed, in some cases, it may result in more recession or with increased spacing between the teeth.

CONSENT TO UNFORSEEN CONDITIONS

I further understand that unforeseen conditions may call for modification or change from the anticipated treatment plan. These may include, but are not limited to, (1) extraction of hopeless teeth to enhance healing of adjacent teeth, including wisdom teeth (2) the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, (3) insufficient bone support for the dental implant(s) or (4) termination of the procedure prior to completion of all of the treatment originally outlined. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my treating doctor.



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NECESSARY FOLLOW-UP CARE AND COMPLIANCE WITH SELF-CARE INSTRUCTIONS

I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of periodontal therapy. From time to time, my Periodontist may make recommendations for the placement of restorations, the replacement or modification of existing restorations, the joining together of two or more of my teeth (splinting), the extraction of one or more teeth, replacement of teeth, bite adjustment, bite appliances (night guard), the performance of root canal therapy, or the orthodontic movement of one, several, or all of my teeth. I understand that the failure to follow such recommendations could lead to ill effects on my mouth and overall general health, which would become my sole responsibility.

I recognize that natural teeth and their artificial replacements (crowns, bridges, partials and/ or dentures) 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. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by my Periodontist and (2) to see my Periodontist and dentist for periodic examination and preventive treatment. If having treatment for periodontal "gum" disease, Periodontal Maintenance at our and/ or your dentist's office is necessary to clean the teeth and gums and to monitor the disease every three to six months. These and other visits may also include periodic adjustment of prosthetic appliances, the bite, etc.

NO WARRANTY OR GUARANTEE

I acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment(s) will be completely successful in eradicating all preexisting symptoms, problems, or complaints. It is anticipated that the surgery will provide benefit in reducing the cause of my condition(s) and produce healing which will enhance the possibility of longer retention of my teeth by reducing the problems associated with this tooth/ these teeth. However, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement, despite the best of care. If having dental implants, I acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed implant(s) will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that the implant(s) will be permanently retained, but because of the uniqueness of every case and since the practice of dentistry is not an exact science, long- term success cannot be promised.

USE OF PHOTOGRAPHS FOR EDUCATIONAL, REIMBURSEMENT, AND SOCIAL MEDIA USES

I authorize Periodontal Associates of Memphis to use any photography, x-rays, video recordings, or other viewings of my oral and facial structures, during any point in my treatment, to be used for reimbursement or scientific purposes, communication with other health care providers, and for educational use in lectures or publications. This includes use of these photographs and/or video in publications, news releases, on social media, and in other communications related to the mission of the practice.



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PATIENT CONSENT TO TREATMENT

I have had the opportunity to ask all of my questions about my treatment and all of my questions have been answered to my satisfaction. I believe I have been given adequate information upon which to base an informed consent. I accept the potential risks, complications, and dangers which may occur with treatment. I read and write English. I have read (or had read to me) this form and fully understand its content I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

PATIENT OR LEGAL GUARDIAN: _____ **Date:** _____

I certify that I have explained the diagnosis, nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the treatment and procedures prescribed for the patient. I have offered to answer any questions and have fully answered such questions. I believe the patient/relative/guardian understands what I have explained and has consented to the proposed treatment and procedures.

DOCTOR: _____ **Date:** _____

I hereby certify that the patient/relative/guardian either: has acknowledged in my presence that he/she has received an explanation and benefits of, risks, and alternatives to, the proposed dental treatment/procedures, usual and most frequent risks and hazards of, and alternatives to the proposed treatment/procedures, has had all of his/her questions answered, has given his/her consent, and has signed this form where indicated; or after the informed consent discussion and signatures above, has answered "yes" to the proposed treatment.

WITNESS CERTIFICATION: _____ **Date:** _____

Last Updated June 26, 2024

ALL CONSENT FORMS SHOULD BE SIGNED AND RETURNED OR FAXED TO OUR OFFICE FIVE (5) DAYS PRIOR TO TREATMENT OR YOUR APPOINTMENT MAY BE CANCELLED. FAX: 901.761.3775



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