Consent for the Chao Pinhole Surgical Technique (PST)

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that I have significant gum recession. I understand that with this condition, further recession of the gum may occur which could lead to premature tooth loss. Additionally, for fillings at the gum line, it is important to have sufficient width of attached gum to withstand the irritation caused by the fillings or edges. Sufficient width of attached gum is also necessary to withstand the repeated forces of tooth brushing and good.

Recommended treatment: In order to treat this condition, my periodontist has recommended that the PST procedure be performed. Local anaesthetic will be administered as part of the treatment. The PST procedure will involve a small pinhole or several pinholes placed under the lip in the vestibule depending on the number of teeth treated. Specially designed instruments will be used to gently loosen and drape the gum tissues over the exposed recessed areas on the teeth. Resorbable collagen will then be placed in the pinholes to increase the width of the gum and secure the tissues in place. Unforeseen circumstances may call for change from the anticipated surgical plan. These may include, but are not limited to: inclusion of additional teeth not originally planned, termination of the procedure prior to completion of all the surgery originally planned and placement of the sutures if indicated. These treatment changes could result in additional billable fees being charged.

Expected benefits: The purpose of the PST procedure is to: create a widened zone of attached gum tissue adequate to reduce the likelihood of additional gum recession and to cover exposed root surfaces in order to enhance the appearance of the teeth and gum line and to prevent/treat root sensitivity or root decay.

Principal risks and complications: The amount of root coverage will depend on many factors including but not limited to: the severity of recession, blood supply to the tissues, amount of tissue and bone loss interproximally (in between the teeth), overall systematic and oral health of the patient and compliance with the post-operative instructions. In addition, the success of PST can be affected by: medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of the teeth, improper oral hygiene and medications that I may be taking. There may be a need for a second procedure if the initial surgery is not satisfactory.

Complications from PST may include but are not limited to: bleeding, bruising and swelling, pain, infection, transient or even permanent tooth sensitivity, temporary or even permanent numbness of the lips, chin and gums, allergic reactions and accidently swallowing or foreign material. The exact duration of any complications cannot be determined and they may be irreversible. To my knowledge I have reported to the periodontist any prior drug reactions, allergies, diseases, symptoms, habits or conditions which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications is important to the ultimate success of the procedure.

Alternatives to suggested treatment: My periodontist has explained alternative treatments for my hum recession and modifications of techniques for brushing my teeth.

Necessary Follow up care and Self-care: I understand that it is important for me to continue to see my regular dentist. I recognise that natural teeth and their artificial replacements should be maintained daily in a clean hygienic manner. I will need to come for appointments after my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of the PST. I know that it is important to abide by the specific prescriptions and instructions given by the periodontist and to see my periodontist and dentist for periodic examinations.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warrant 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 optimum healing which will help me keep my teeth. Due to individual patient differences, a periodontist cannot predict certainty of success. Rarely, there is a risk of failure, relapse, additional treatment or even a worsening of my present condition including the possible loss of certain teeth, despite the best of care.

Use of records: I authorise photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for reimbursement or teaching purposes.

 Please tick here if you do not want your photos to be used for these purposes.

PATIENT CONSENT:

I have been fully informed of the nature of PST, the procedure to be utilized, the risks and benefits of PST, the alternative treatments available, and the necessity of follow-up and self-care. I have had an opportunity to ask any 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 PST as presented to me during my consultation and in the treatment plan presentation. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READY AND FULLY UNDERSTOOD THIS DOCUMENT

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

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian name if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pinhole Gum Rejuvenation

Post Op Instructions for 6 weeks

• NO BRUSHING OVER SURGICAL SITE(S).

• NO FLOSSING (Water-Pik ONLY from tongue-side or inside on low).

• NO TOUCHING: with finger or any other device or object.

• Do not lick surgical area.

• Do not use cotton swabs, cloth or any soft or hard object to clean area.

• Do not sleep with hands under the cheek where surgery was done.

• No facial massages for 3 weeks or massage that area of the face for any reason.

• NO LOOKING: Do not obsess over or question Doctor about appearance of gums for 6 weeks. You cannot look without pulling the cheek.

• RINSE ONLY WITH LIPS APART: SLOSHING ONLY.

• No Chipmunk cheeks when you rinse.

• Do not play wind instruments for 3 weeks.

• Do not suck on straws.

• Do not blow balloons.

• No spitting.

• No mints over surgical area.

• No smoking, chewing tobacco, cigar, pipe.

• WEAR PRESCRIBED BITE APPLIANCE 24 HOURS A DAY, if instructed. Check with doctor about any other appliances (e.g retainers, Invisalign, Perio-Protect, etc).

• No clenching or grinding of the teeth.

• No heavy lifting that require clenching of the teeth.

• No heavy aerobics, vigorous dancing or physical activity for 6 weeks.

• ICE OVER AREA at 10 minute intervals for the first 48 hours to minimize swelling.

• DO NOT BE ALARMED ABOUT SOFT SWELLING OR BRUISING FOR THE FIRST WEEK.

• DO NOT EAT crunchy or sticky food that can get stuck on or in between your teeth.

• EXPECT cold sensitivity for 6 weeks or longer. DO REPORT sensitivity during check-up appointments.

• PAIN CONTROL- take your normal pain medication as required, subject to other instructions by your doctor.

• CALL DOCTOR IMMEDIATELY IF YOU HAVE UNEXPECTED PAIN, CONTINUOS BLEEDING OR HEAT FROM THE SURGICAL SITE.

• Patient MUST return to our practice 24 hours after surgery, 1 week after surgery, 3 weeks after surgery, and 6 weeks after surgery.

• After the 6th week you may brush the surgical area with a special extra soft brush dispensed or ordered by this office for 6 MONTHS.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (day of surgery)

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (next day)

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1 week)

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3 weeks)

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (6 weeks)