CONSENT TO LANAP PERIODONTAL (GUM) SURGERY

I hereby authorize Dr. Jonathan R Tiger (hereinafter called "Doctor" to perform the **LANAP (Laser Assisted New Attachment Procedure)** periodontal surgery and associated procedures described below upon

(Name of Patient) _____

Laser gum pocket surgery in these areas of the mouth

_____

_____

Bite adjustment by grinding and reshaping my teeth, fillings, and crowns – everywhere

I have been informed that the purpose of the operation is to surgically treat and probably correct my periodontally diseased gum tissues, teeth, bite, and supporting jawbones or to rebuild lost tissues, using a laser instead of traditional scalpel surgery.

This type of surgery is performed after the area being treated is anesthetized (numbed) in the standard manner with local injections of anesthetic solution that contain vasoconstricting drugs.

If I have requested or agreed to have sedative drugs (pills) administered before surgery, I agree that I will not drive myself home after surgery, but will arrange to be driven and accompanied home by

(Name of Driver)_____

I further acknowledge that I have made arrangements for an adult to care for me while the sedative drugs still have an effect (usually 2-6 hours).

In the event that extraction of any teeth is deemed advisable by the Doctor due to the conditions visualized and determined at the time of surgery, I hereby consent to all such extractions.

If any unforeseen conditions should arise in the course of the operation that call for the Doctor's judgment or for procedures in addition to or different from those now contemplated, I further request and authorize the Doctor to do whatever he may deem advisable and in my best interest. I understand that there may be additional fees associated with such additional treatment.

Furthermore, I have been informed that alternatives to laser surgical treatment include: doing nothing; extracting the involved teeth; traditional flap surgery; or frequent, repetitive deep cleanings to attempt to attempt to slow down the disease process. However, I have agreed to have the LANAP laser surgical treatment performed in order to more directly treat the problems in my mouth.

Date _____ Patient Initials_____

Re-treatment/re-entry_____ Initials_____

I realize that all periodontal rebuilding techniques that try to increase the amount of gum and bone tissue attachment to the tooth are often only partially successful and may require a second stage corrective surgery after several months to complete the treatment (additional fee to be charged).

Post-operative risks of the proposed surgery include but are not limited to: swelling; infection; discomfort; restricted mouth opening for several days or weeks; paresthesia (numbness) of the jaw or gum nerves which may persist; gum recession (shrinkage); interference with phonetics (speech sounds) ; sensitivity to hot or cold for days, weeks, or on rare occasion, months; transient, or in some instances, permanent, food lodging between the teeth after meals requiring cleaning devices such as special brushes or floss for removal; and unesthetic exposure of crown (cap) margins or root surfaces.

I further understand that if no treatment or limited non-surgical treatment is rendered, my present periodontal condition will probably worsen in time, which may result in tooth loss.

NO GUARANTEE, WARRANTY, OR ASSURANCE HAS BEEN GIVEN TO ME THAT THE PROPOSED TREATMENT WILL BE SUCCESSFUL TO MY COMPLETE SATISFACTION. DUE TO INDIVIDUAL PATIENT DIFFERENCES, THERE EXISTS A SMALL RISK OF FAILURE, RELAPSE, SELECTIVE RE-TREATMENT NEED, OR WORSENING OF MY PRESENT CONDITION DESPITE THE BEST OF CARE. HOWEVER, IT IS THE DOCTOR'S OPINION THAT THERAPY WILL BE HELPFUL AND ANY FURTHER LOSS OF SUPPORTING TISSUES OR BONE WOULD OCCUR SOONER WITHOUT THE RECOMMENDED TREATMENT.

I understand that healing after gum and bone surgery has been shown to be impaired by smoking, alcohol, high stress, heavy uneven bite forces, and poor nutrition. I agree to limit these adverse factors as much as possible and to follow my doctor's post-operative and home care instructions.

I understand that long-term success requires my long-term continued performance of effective personal plaque control (daily home care) and my receiving periodic periodontal maintenance visits (recall professional care). I understand the one year follow-up cleaning and bite adjustment schedule. The most common long term recall interval is 2-4 months for professional periodontal cleanings and evaluations.

I consent to the taking of photographs and slides, and/or video tapes, and/or x-rays of my oral and facial structures and to their publication for educational and scientific purposes. I understand that I will not be identified in any of these presentations.

Signed _____ Date_____

Witness_____ Doctor_____