Michael A. Pawlus, D.D.S., M.S.
(Practice Limited to Periodontics and Dental Implants)
Office Tel: (941) 923-2288 – (941) 484-9205

CONSENT FOR SURGERY
(PLEASE READ AND RETURN ON THE DAY OF SURGERY)

Diagnosis

After a careful oral examination and study of my dental condition, Dr. Pawlus has advised me that I need: **Free Gingival Graft, Sub epithelial Tissue Graft, Crown Lengthening, Frenectomy, Soft Tissue Biopsy.**

Recommended Treatment

This surgical procedure has been explained to my full satisfaction by Dr. Pawlus. I understand that local anesthetics will be administered and sedation may be utilized. I further understand that antibiotics may be utilized during surgery. I also understand that unforeseen conditions may call for a modification or change from the planned surgical procedure. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth or removal of a hopeless root of a multi rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of the originally planned surgery.

Risks and Complications

I understand that there is a small possibility that some patients do not respond totally successfully to surgery and there may be in some cases a slight change in appearance. I further understand that complications may result from any surgical procedure. Such complications may include, but are not limited to, post surgical infection, bleeding and swelling, slight bruising or numbness, discomfort and transient tooth sensitivity. Most complications will be temporary and the exact duration cannot be determined. There is a small risk for failure, relapse or the need of additional treatment. I understand that a periodontist cannot guarantee or predict the certainty of the success of the recommended treatment. **The success of surgical procedures can be affected by medical conditions, smoking, alcohol consumption, inadequate oral hygiene, and medications that I may be taking.**

Necessary Follow up Care

It is important to professionally monitor my oral health. I understand that my diligence in providing the personal daily care recommended by Dr. Pawlus taking all prescribed medications are important to the ultimate success of the procedure. To my knowledge, I have reported to Dr. Pawlus any prior drug reactions, allergies, diseases, symptoms, habits or conditions which might in any way relate to the surgical procedure. *I will need to come for appointments following any surgery so that healing maybe monitored and so that Dr. Pawlus can evaluate and report on the outcome of the surgery upon completion of healing.*

PATIENT CONSENT

I have been fully informed of surgery, the procedure to be utilized, the risks and benefits of the necessity for 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 Dr. Pawlus. After thorough deliberation, I hereby consent to the performance of surgery as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist, Dr. Pawlus.

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

Printed Name Patient, Parent, or Guardian	Signature	Date

Printed Name Witness	Signature	Date