Gingivectomy Informed Consent

Gingivectomy is a type of surgery that involves the removal of excessive gum tissue. It is impossible to adequately clean teeth with deep gingival pockets- toothbrush bristles cannot reach more than 4mm down into the sulcus. Plaque left on our teeth will eventually harden, due to the minerals in our saliva, and become tartar (calculus). This calculus is a hard deposit that requires removal using sharp instruments. Brushing and flossing are no longer sufficient to clean teeth when calculus is present.

A gingivectomy is performed to reduce pocket size to allow for proper home care. It is done in conjunction with Scaling & Root Planing (SRP) appointments to manage gum disease (periodontitis). Further procedures may be required to ensure good symmetry and aesthetics.

All dental treatments have an associated risk. The complications of periodontal surgery may include, but are not limited to: bleeding, swelling, bruising, pain, infection, sore jaws, recession, tooth sensitivity, and caries exposure. Every patient responds to treatment differently. Therefore, it is impossible for the doctor to accurately predict estimated healing time and the aesthetic results of the procedure.

Smoking and poor oral hygiene will significantly interfere with healing and cause disease recurrence. Medical history must be updated & accurate before surgery is performed.

If no treatment is rendered, or if active treatment is interrupted or discontinued, the periodontal condition will continue to progress. This may result in pain, swelling, bleeding, infection, recession, mobility, decay, staining, bone loss, and tooth loss.

PATIENT CONSENT: I, _____(print name) have been fully informed of the surgery to be performed. I understand the risks and benefits of the procedure, alternative treatments, and the necessity for follow-up and self care. I understand the potential outcome of not undergoing treatment. I am aware that additional treatment may be necessary. I have had an opportunity to ask my doctor any questions, all of which have been answered to my satisfaction.

_____   _____
Patient Signature   Date

_____   _____
Provider Signature   Date

_____   _____
Witness Signature   Date