NOSE

CREEK

DENTAL

CENTRE

#1, 409 – 1 Avenue

Airdrie, AB T4B 3E2

(403)948-6684

Date Procedure Completed _____

Consent for ALLODERM TISSUE GRAFT

This is my consent for Dr. Townsend to perform the following:

Procedure _____ for Name _____

The Dentist and/or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

*My dentist has explained forms of treatment. I have chosen the "AlloDerm" graft – freeze dried acellular dermal graft.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discolouration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible. Also, if "AlloDerm" is exposed, I understand that I might notice a bad taste or colour change of the membrane. Repositioning of tissues procedure may also be required.

I understand that if I decide not to undertake any treatment, the following complications can occur worsening of gingival recession, root cavities, periodontal disease, tooth mobility and sensitivity that may require extraction.
I am aware that **one week** prior to treatment I will stop taking fish oils /vitamin E supplements.

I am aware that each patient heals in different manner after graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

*I understand that smoking, vaping, drinking alcohol, or uncontrolled blood sugar levels can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post-operative instructions from my dentist. I will respect appointments and have my graft checked as well as have regular checkups.

To my knowledge, I have given the proper medical information regarding my physical and mental states (medications, diseases, syndromes, etc.). I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition, I have mentioned any abnormal reactions of the gums, skin, any abnormal bleeding, or any conditions in relation to my overall health.

Patient Signature _____

Doctor Signature _____

Date _____