NOVEL DENTAL
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Free Gingival Graft Consent Form

Patient Name: ---------- DOB: ----------

I authorize *Dr Faraz Hedayat-Seresht* (Dentist) to perform free gingival graft of the tooth/teeth # ------

The reasons and benefits of this treatment have been explained to me.

The Dentist has explained the effect, nature and Consequence of such an operation to me.

I also consent to the administration of local anesthetics for these purposes.

I am informed that at surgery time, the plan may change or some referral to specialist may be required

I understand that this procedure involves some surgery on my palate as well

As with any treatment involving the body, there are some inherent risks and limitations. I have been informed of possible risks and complications involved with surgery, drugs and anesthesia.

Such complications include, but are not limited to:

- Pain
- Swelling
- Bleeding
- Infection
- Injury to the present teeth
- Bone Fractures
- Sinus Penetration (Upper jaw)
- Delayed Healing
- Allergic Reactions to drugs or medications used
- Some limitation in lip movements
- Numbness of the lip, palate, cheek, or teeth
  The exact duration may not be determinable and may be irreversible.

Although these risks, complications and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.
The dentist has provided greater detail on the above complications to me verbally.
I understand that smoking can **seriously** affect post-operative healing and final result
To my knowledge I have given an accurate report of my physical and medical history.

Patient Signature. ---------- Date. ----------

Dentist Signature. ---------- Date. ----------