Family Smile Center, LLC
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Frederick, MD 21704
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INFORMED CONSENT FOR CONNECTIVE TISSUE GRAFT

Teeth area:____

The Connective Tissue Graft is being done with my approval.

I have been informed of alternative treatments which include: No Treatment, Free Gingival Graft, Restoration, Desensitizing Treatment, and Extraction.

I understand that if this Graft is not done my condition may worsen resulting in complications including but not limited to:

1. Root Caries
2. Pain
3. Loss of the involved tooth

Possible complications from the procedure discussed with me include, but are not limited to:

1. Infection
2. Swelling
3. Bruising
4. Inadequate attachment gain
5. Loss of the Graft
6. ____

I understand that the success of this procedure depend upon my cooperation and home care. If I do not follow the post operative instructions given, the success of this procedure may be reduced.
I understand the risks and consequences of this type of treatment.
All of my questions have been answered.

_______________________________	_______________________________
Signature of Patient	Date
_______________________________	_______________________________
Signature of Doctor	Witness