Consent for Frenectomy Surgery

Patient Name: _____ **Date:** _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

Diagnosis: After a careful oral examination and study of my dental condition, I have been advised by my surgeon that I have excessive gum tissue between my jaw and anterior incisors (Frenum).

In order to treat this condition, my surgeon has recommended my treatment include gum surgery in order to remove the frenum. I understand that sedation may be utilized and a local anesthetic will be administered to me as part of the treatment.

This is my consent for my surgeon and his/her surgical team who is working with him/her, to perform the following treatment/procedure/surgery:

- □ Labial frenectomy, the muscle attachment will be released between my two central incisors using laser.
- □ Lingual frenectomy, the tissue attachment will be incised below the tongue using laser.

_____1. Expected benefits: healthier tissue, aesthetics, and tooth stability.

_____2. I understand that it is important for me to continue to see my regular dentist. Existing restorative dentistry can be an important factor in the success or failure of frenectomy surgery. From time to time, the doctor may make recommendations for the placement of restorations, the replacement or modification existing restorations. I understand that failure to follow such recommendations could lead to ill effects, which would become my sole responsibility. I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and for the doctor to evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know it is important to abide by the specific prescriptions and instructions given and my general dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

_____3. My surgeon has explained to me that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance such operative risks include, but are not limited to:

a. a small number of patients do not respond successfully to frenectomy surgery and because each patient's condition is unique, long-term success may not occur
b. post-surgical infection
c. bleeding, swelling and pain
d. facial discoloration
e. transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum
f. jaw joint injuries or associated muscle spasm, transient but on occasion permanent
g. increased tooth looseness
h. tooth sensitivity to hot, cold, sweet, or acidic foods
i. shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks
j. impact upon speech
k. allergic reactions and accidental swallowing of foreign matter

I understand that there is no method that will accurately predict or evaluate how my frenectomy will heal, and understand that there may be a need for a second procedure if the initial results are not fully satisfactory. This may be due to unforeseen reasons, accidents or trauma to the area, or loss of blood supply. In addition, the success of periodontal procedures can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to the doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions which might in any way relate to this surgical/anesthetic procedure. I understand that my diligence in providing the personal daily care recommended by the doctor and taking all prescribed medications are important to the ultimate success of the procedure.

_____4. I understand that alternatives to frenectomy surgery include: no treatment. I also understand that with no treatment the expectation of possible advancement of my condition may result in premature loss of teeth and/or in impairment of my general health.

_____5. I consent to the administration of **local anesthesia**. I am aware that local anesthesia has potential risks and complications; swelling, bleeding, bruising and possible nerve injury, usually temporary causing prolonged numbness and discomfort in the injected areas.

_____6. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

_____7. I have had an opportunity to discuss with my surgeon my past medical and health history including any serious problems and/or injuries.

_____8. I agree to cooperate completely with the recommendation of my surgeon while I am under his/her care, realizing that failure to do so could result in a less than optimal result.

FEMALE PATIENTS ONLY:

_____ It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medications are completed.

I certify that I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to. I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, write and understand English.

My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient *(or Legal Guardian)* Signature **Date**

Witness Signature **Date**

Doctor Signature **Date**