CONSENT FOR FRENECTOMY SURGERY

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Patient's Name Date

During your consultation we discussed your need for frenectomy surgery, steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure. **Please initial each paragraph after reading, if you have any questions please ask your periodontist before initialing and signing on the last page.**

______***1. Diagnosis.*** After a careful oral examination and study of my dental condition, my periodontist has advised me that I have a frenum attachment problem (excessive tissue between my jaw and anterior incisors), which may be affecting my dental health and orthodontic stability. I understand that with this condition, gum problems or orthodontic relapse (recurring tooth movement) may occur. In some cases, a frenum may interfere with speech, appearance or function.

______***2. Recommended Treatment.*** In order to treat this condition, my periodontist has recommended that a frenectomy (frenum removal) procedure be performed in areas of my mouth associated with these tissues. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. This surgical procedure involves the removal of a strip of tissue from the associated area(s) of my mouth. A laser or surgical blade may be utilized to complete the procedure. Sutures, tissue adhesives or periodontal bandage may be placed.

______***3. Expected Benefits.*** The purpose of the frenectomy is to reduce the likelihood of orthodontic relapse, tissue recession, speech, esthetic and/or functional issues. Revision of the tissues of the surrounding teeth, including the gum contour, gum position and papilla (tissue between the teeth) may likely occur to achieve the desired outcome. Tissue color changes may sometime occur which may be transient or permanent.

______***4. Principal Risks and Complications.*** I understand that a small number of patients do not respond successfully to frenectomy procedures. In some cases, the attempt to remove the frenum may not be completely successful or the frenum may reattach. In these cases, the procedure may need to be repeated. I understand that complications may result from a frenectomy procedure or from dental anesthetics. These complications include, but are not limited to (A) post-surgical infection, (B) bleeding, swelling, and pain, (C) facial discoloration, (D) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods, (E) allergic reactions, (F) transient or permanent numbness of lips teeth or tissues and (G) accidental swallowing of foreign matter. The exact duration of any complication cannot be determined, and they may be irreversible.

______***5. . No Warranty or Guarantee.*** No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences there can never be a certainty of success, despite the best of care. There is no method that will accurately predict or evaluate how my gum and underlying bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory. In addition, the success of a frenectomy can be affected by (A) medical conditions, (B) dietary and nutritional problems, (C) smoking, (D) alcohol consumption, (E) clenching and grinding of teeth, (F) inadequate oral hygiene, (G) physical disruption (i.e. contact sports) and (H) medications that I may be taking. To my knowledge, I have reported to the periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications is important to the ultimate success of the procedure.

______***6. Alternatives to Suggested Treatment.*** My periodontist has explained alternative treatments for my frenum problem. These include no treatment and continued monitoring for progressive tissue disturbances, speech problems, esthetic concerns, and functional disruption or tooth movement.

______***7. Necessary Follow-Up Care and Self-Care.*** I understand that it is important for me to continue to see my regular dentist and/or orthodontist. Existing restorative dentistry, hygiene maintenance and orthodontic treatment can be an important factor in the success or failure of my surgical treatment. I recognize that natural teeth and their artificial replacements 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 so that my periodontist

can 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 that it is important (A) to abide by the specific prescriptions and instructions given by the periodontist and (B) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustments of prosthetic appliances.

______***8. No Warranty or Guarantee.*** I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing, which will help me, keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

______**9. Publication of Records**. I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion is used for the advancement of dentistry and reimbursement purposed.
My identity will not be revealed to the general public, however, without my permission.

______***10. Females only.*** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the frenectomy surgery, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the frenectomy surgery as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document.

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Patient's Signature (or patient's guardian) Date

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Witness Signature Date