

## INFORMED CONSENT FOR FRENECTOMY SURGERY

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

**Recommended Treatment:** In order to treat this condition, the dentist has recommended my treatment include gum surgery in order to remove the frenum. I understand that a local anesthetic will be administered to me as part of the treatment. For the frenectomy, the excess tissue will be removed and the tissue between my two central incisors will be traumatized to allow for healing with a scar.

**Expected Benefits:** Healthier tissue, better aesthetics and tooth stability.

**Necessary Follow-Up Care and Self Care:** I understand that it is important for me to continue to see my dentist. Existing restorative dentistry can be an important factor in the success or failure of frenectomy surgery. From time to time, the dentist 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 (1) to abide by the specific prescriptions and instructions given by the dentist and (2) to see my dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

**Principal Risks and Complications:** I understand a small number of patients do not respond successfully to frenectomy surgery. Because each patient's condition is unique, long-term success may not occur.

I understand that complications may result from the gum surgery including post surgical infection, bleeding, swelling and pain; facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum; jaw joint injuries or associated muscle spasm, transient, on occasion permanent; increased tooth looseness; tooth sensitivity to hot, cold, sweet, or acidic foods; 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; impact upon speech; allergic reactions and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my frenectomy will heal. I understand 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.

**Alternatives To Suggested Treatment:** I understand that alternatives to frenectomy surgery include (1) no treatment- with the expectation of possible advancement of my condition which may result in premature loss of teeth and/or in impairment of my general health.

**No Warranty Of Guarantee:** I hereby acknowledge no guarantee, warranty or assurance has been given to me that the proposed 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, the doctor cannot predict certainty of success. There is a risk of failure, relapse, additional treatment or worsening of my present condition, including the possible loss of certain teeth, despite the best care.

**Publication Of Records:** I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes.

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of the frenectomy surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the frenectomy surgery as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the dentist. I have read and understand this document before I signed it.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Atlanta Dental Group PC 1624 Piedmont Avenue, NE Atlanta, Georgia 30324 (404) 874-7428  
Copyright Dr. Mark Allan Padolsky 2008