NORTHEAST
Dental Group

Northeast Dental Group

'A Dental Destination Location'

7770 Frontage Rd #7341
Cicero, NY 13039

CONSENT FOR FRENECTOMY SURGERY

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

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)

My planned treatment is: In order to treat this condition, the doctor 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.

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.
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.

1. ____ Expected Benefits: Healthier tissue, aesthetics, and tooth stability.
2. ___ Necessary Follow-Up Care and Self Care: 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 (1) to follow the specific prescriptions and instructions given by the doctor and (2) to see the doctor and my general dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.
3. ____ 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.

4. ____ 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.

5.____ 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 is important to the ultimate success of the procedure.

6. ___ No Warranty or 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.

7. ____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. My identity will not be revealed to the general public without my permission.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date