Frenectomy

Informed Consent Form

Diagnosis:

After a thorough oral examination, I have been advised that the reduction of a frenum may help to restore anatomy, function, aesthetics and/or possibly prevent commonly associated future problems.

Recommended Treatment:

In order to treat this condition, my dentist has recommended that a frenectomy be performed at the selected site(s). A scalpel will be used to eliminate the frenum and stiches will be placed in its space.

Principle Complications:

I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a minority of cases. These complications include, but are not limited to post- surgical, bleeding, infection, swelling, pain, damage to adjacent structures such as salivary glands, nerve, muscle, and skin.

A more common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar, keloid, or overt fibrous tissue formation.

Follow Up Appointments:

I am advised to return for a 1week check, and a 3 week check to follow up on the proposed care.

Photos may be taken, but not of the face without permission

Alternatives to Suggested Treatment:

I understand that alternatives to a frenectomy include: no frenectomy,with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including the gums and teeth.

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. I do expect however that the doctor perform the surgery to the best of his/ her ability.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL MY QUESTIONS WERE ANSWERED

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/ Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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