

**I have been informed** of the presence of a **frenum** that might be exceptionally short, thick, tight, or may extend too far down along the gum. When a frenum is positioned in such a way as to interfere with the normal alignment of teeth or to impinge on the gingiva (gums), it can be excised with surgery called a **Frenectomy**. A **frenectomy** is a simple surgical procedure that removes or loosens a band of tissue that is connected to the lip, cheek or floor of the mouth. The surgery can cause minor bleeding and can result in some post-procedure discomfort. The procedure will be performed using a local anesthetic.

**I understand that Periodontal Procedures and Frenectomy Surgery** (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. I agree to assume those risks and possible unsuccessful results associated with, but not limited to the following: (Even though the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions, there are no promises or guarantees as to anticipated results.)

**1. Response to Treatment:** Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process in which tissue response is a vital element will achieve the results desired by the attending dentist and hygienist as well as the patient.

**2. Postoperative Patient Responsibility for Care:** With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment as instructed by the treating dentist and/or hygienist. Without the necessary follow-up care by the patient, the probability of unsatisfactory or unsuccessful results is greatly increased.

**3. Infection:** On occasion, postoperative infections(s) may occur. This may range from mild to severe in nature. Should you have any concerns related to this potential problem, this office should be contacted as soon as possible.

**4. Bleeding, Bruising, and Swelling:** Following Frenectomy surgery, there are occasions when bleeding may occur. Instructions as to how this may be controlled will be given to you. Some bruising and/or swelling of the intraoral and facial tissues may occur. If extreme, it is your responsibility to contact this office.

**5. Reaction to Medications or Anesthetics:** Allergic reactions may exhibit themselves which may be of mild to very severe in nature relative to medications, materials, and/or anesthetics. It is the responsibility of the patient to fully inform the dentist or hygienist of any past allergic reactions.

**6. Injury to the Nerves:** There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue, or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which may occur is usually temporary, but in rare instances could be permanent.

**7. Pain and Soreness:** Frenectomy surgery may be followed by mild pain and soreness around the operated area. Instructions will be given as to the methods of controlling the problems of pain and soreness.

**It is the patient's responsibility to seek attention should any undue circumstances occur postoperatively** and the patient shall diligently follow any preoperative and postoperative instructions given them.

**Informed Consent:** I have been given the opportunity to ask any questions regarding the nature and purpose of **Periodontal Treatment and Frenectomy Surgery** and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize this practice and/or their hygienists or associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications. I understand it is my responsibility to inform the doctor of ALL the medications I am currently taking as well as any allergies.

## Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to use Electronic Records and Signatures.: [  ]

Relation to Patient:

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

I consent to use Electronic Records and Signatures.: [  ]