

## CONSENT FOR THE EXPOSURE OF AN IMPACTED TOOTH

**DIAGNOSIS:** After a careful examination and study of my dental condition, and with consultation with my orthodontist, Dr. Yaholnitsky has advised me that the impacted tooth could be exposed.

**RECOMMENDED TREATMENT:** In order to move the impacted tooth orthodontically, a small window must be made in the gum tissue. The exposed tooth will then have an orthodontic button bonded to its surface and an attached chain connected to the arch wire. Your orthodontist will then move the tooth into position.

I understand that oral sedation may be utilized and that local anesthetic will be administered to me as part of the treatment. Antibiotics and other medications may be given. During this procedure, incisions will be made in the gum tissue at the location of the tooth. Some bone removal may be required to fully expose the surface of the impacted tooth. Incisions are sometimes closed with sutures. I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan.

**EXPECTED BENEFITS:** The purpose of the surgical exposure is to allow for the impacted tooth to be orthodontically moved into the proper position.

**PRINCIPLE RISKS AND COMPLICATIONS:** I understand that the procedure may not be successful and in very rare circumstances has to be repeated. Complications that may result from surgery could involve the surgery procedure, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the comers of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions permanent) numbness of the lip, chin or gums. The exact duration of any complication cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum will heal. There may be a need for a 2nd procedure if the initial results are not satisfactory. In addition, the success of surgery can be affected by medical conditions, dietary and nutritional problems, smoking, excessive alcohol consumption, snuff and chewing tobacco, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to Dr. Yaholnitsky any prior drug reaction, allergies, diseases, symptoms, habits or conditions that 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 medications prescribed are important to the success of the procedure.

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**ALTERNATIVES TO SUGGESTED TREATMENT:** I understand that the alternative to a frenectomy is no treatment.

**NECESSARY FOLLOW-UP CARE AND SELF-CARE:** It is important for me to continue to see my regular dentist for routine dental care. I understand smoking and smokeless tobacco may adversely affect healing and may cause pain and/or a poor result, especially if used during the 1 st month.

I have told Dr. Yaholnitsky about any pertinent medical conditions I have, known allergies (especially to medications), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Yaholnitsky about any present or prior head and neck radiation therapy. I have told Dr. Yaholnitsky about any present or prior use of bisphosphonate medications. Some common brand names are Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®.

I need to come back in for several post-operative check-ups so that healing may be monitored and so Dr. Yaholnitsky can evaluate and report on the outcome of surgery to my dentist.

I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr. Yaholnitsky for post-operative check-ups as needed.
3. No smoking or use of smokeless tobacco for 1 month as noted above.

**NO WARRANTY OR GUARANTEE:** While in most cases the surgical exposure heals quickly and without any problems, complications such as those listed previously, can happen despite the best of care.

**PUBLICATION OF RECORDS.:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry, in written or internet publications or sites, and in promotional materials. My identity will not be revealed to the general public.

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**PATIENT CONSENT:**

I have been informed of the nature of exposing the impacted tooth, the procedure to be utilized, the risks and benefits of this surgery, the alternative treatments available, and the necessity for follow-up 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 Dr. Yaholnitsky and his staff members. After thorough deliberation, I hereby consent to the performance of the dental surgery as presented to me during consultation as described above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Yaholnitsky.

Date [Printed name of patient, parent or guardian]

[Signature of patient, parent or guardian]

Date [Printed name of witness]

[Signature of witness]