CONSENT FOR A FRENECTOMY

DIAGNOSIS: After a careful examination and study of my dental condition Dr. Yaholnitsky has advised me that a small skin/muscle attachment between the gum and cheek should be reduced. This attachment may cause the separation of teeth, prevent orthodontic movement or cause recession of gum tissue on adjacent teeth

RECOMMENDED TREATMENT: In order to treat this condition, it has been recommended that the frenal attachment be surgically reduced.

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, the frenum is pinched with surgical forceps and then reduced with incisions on either side of the instrument. All incisions are 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 a frenectomy is to improve esthetics, prevent gum recession and to allow for stable, orthodontic movement of teeth.

PRINCIAP 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.

Initials_____

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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. Not smoking or use of smokeless tobacco for 1 month as noted above.

NO WARRANTY OR GUARANTEE: While in most cases a fenectomy 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.

Initials_____

PATIENT CONSENT:
I have been informed of the nature ofa frenectomy, 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 oral 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]