CONSENT FOR A FIBROTOMIES

DIAGNOSIS: After a careful examination and study of my dental condition, my orthodontist has advised me that the small fibres surrounding certain teeth, need to be released. These fibres may cause the associated teeth to relapse towards their original, pre-orthodontic position.

RECOMMENDED TREATMENT: In order to prevent the relapse, it has been recommended that circumferential fibrotomies be completed.

I understand that local anesthetic will be administered to me as part of the treatment. During this procedure, a sharp instrument will be utilized to release the connective tissue fibres from the neck of the teeth. No sutures will be required. I understand that unforeseen conditions may call for a modification or change from the anticipated surgical plan.

EXPECTED BENEFITS: The purpose of the fibrotomies is to prevent rotation of individual teeth back towards their pre-orthodontic position

PRINCIPLE RISKS AND CO~rLICATIONS: 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, cracking or bruising of the comers of the mouth, impact on speech, allergic reactions and tooth sensitivity to hot, cold, sweet or acidic foods. , 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. 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_____

ALTERNATIVES TO SUGGESTED TREATMENT: I understand that the alternative to exposing the impact tooth is to have the tooth extracted or 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 fibrotomies 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 andto 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]