CONSENT FOR FRENECTOMY

Diagnosis. After a careful oral examination and study of my dental condition, my periodontist has advised me that I have a frenum that may be contributing to gum recession, inhibiting closure of space between my teeth or add undesired tension on tissue during healing of other periodontal surgeries such as soft tissue grafting. The muscles of the cheeks and lips are attached to the gums and tissue of the mouth by a piece of soft tissue called a frenum. Sometimes a frenum can be attached too high on the gums causing either recession or spaces between teeth. In addition, there is another frenum under the tongue. If this frenum is attached too close to the end of the tongue it can adversely affect swallowing and speech. Sometimes this is referred to as being "tongue-tied". I understand that with this condition, further recession of the gum may occur; teeth may not remain or move together with orthodontics, or compromise the result of soft tissue grafting.

Recommended Treatment. In order to treat this condition, my periodontist has recommended that a frenectomy be performed in areas of my mouth with the tissue involved. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. This surgical procedure where either part or all of the frenum in question is removed in order to return a healthy balance to the mouth. The tissue is then sutured closed; however, may be left to heal in without the use of suture as well.

Expected Benefits. The purpose of a frenectomy is to remove tissue that may contribute to gum recession, interfere with the orthodontic closure of space between teeth, or interfere with the success of gum grafting procedures. If attached to the tongue, the procedure will allow greater freedom of movement of the tongue.

Principal Risks and Complications. I understand that a small number of patients do not respond successfully to frenectomy. Risks include reformation of the frenum in full or partially, damage to the gum between the front teeth, reaction to the anaesthetic, and bleeding.

I understand that complications may result from surgery or from anesthetics. These complications include, but are not limited to:
1) post-surgical infection,
2) bleeding, swelling and pain,
3) facial discoloration,
4) transient or on occasion permanent tooth sensitivity to hot, cold, sweet or acidic foods,
5) allergic reactions, and
6) accidental swallowing of foreign matter.

The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory.

Alternatives to Suggested Treatment. My periodontist has explained alternative treatments for my aberrant frenum. These include no treatment and continued monitoring for progressive recession or return of space between teeth.

Necessary Follow-Up and Self-Care. I understand that it is important for me to continue to see my regular dentist. I recognize that natural teeth and their artificial replacements should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions

and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventive treatment. Maintenance also may include adjustment of prosthetic appliances.

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. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records. I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Governing Law. I agree that the relationship between me and the dentist shall be governed and construed in accordance with the laws of the province of Ontario.

Jurisdiction. I acknowledge that the treatment /service is to be performed in the province of Ontario, and agree that the courts of the province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment.

PATIENT CONSENT

I have been fully informed of the nature of a frenectomy procedure, the method to be utilized, the risks and benefits of such surgery, the alternative treatments available and the necessity for follow-up and self-care. I have had the opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of frenectomy procedure(s) as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

_____ _____

Date (Printed Name of Patient, Parent or Guardian)

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(Signature of Patient, Parent or Guardian)

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Date (Printed Name of Witness)

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(Signature of Witness)