Consent for crown Lengthening Surgery

Diagnosis: When a tooth is fractured or decay extends below the gum line, the bone and gum needs to be reduced in size around the teeth in order to get access to remove and restore the cavity, or to fix the tooth and place a filing or crown past the fracture. In order for the gum to heal against the tooth in the healthy manner there must be 3 millimeters of healthy tooth between the margin of a filling or crown and the crest of bone, which supports the tooth. This allows for proper attachment of the gum to the tooth.

In the case of case of a gummy smile, my gums need to be reduced in size so my teeth have a more normal appearance

Recommended Treatment: After an examination and study of my dental condition, my dentist has advised me that I would benefit from a crown lengthening surgery. Local anesthetic (commonly called novocaine) will be administered as part of the surgery, the gum tissue and bone will be reshaped. The gum will then be sutured back closer to the new bone level, and a periodontal dressing (like a plaster pack) might be placed. The surgery will make it look like the gum receded, making the teeth look longer and have spaces between them are expected since we are trying to get better access for my dentist to fix the tooth.

Expected Benefits: The purpose of crown lengthening surgery is to give access for my dentist to correctly restore the tooth or teeth, as better access and visualization of the area are needed. The surgery is intended to help me keep my tooth/teeth in the operated area.

Principal Risks and Complications: Some patients do not respond successfully to crown lengthening periodontal surgery. Unforeseen conditions may call for modification or change from the anticipated surgery plan. These may include, but are not limited to,

1. Extraction of the tooth or teeth that are to be crown lengthened if they are found to be non-restorable (if a crown or filling cannot be done due to a very cavity or fracture, or
2. Termination of the procedure prior to completion of the surgery as originally outlines.

Other thing in the future, such as accidents, root canal problems, tooth decay, periodontal disease, etc. Could also cause the loss of the tooth/teeth we are trying to treat with crown lengthening surgery.

Initials_____

Sometimes complications may result from the crown lengthening surgery or from anesthetics/drugs. 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 corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, and transient (on rarest of occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions

permanent) numbness of the jaw, lip, tongue, 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 the gum and bone will heal before the surgery is done. I understand that there may be a need for a second surgery if the initial results are not satisfactory.

Alternatives to suggested Treatment: Alternatives to crown lengthening surgery include:

1. No treatment. I understand that if no treatment is done, my dentist may not be able to place a restoration.
2. Extraction of the tooth or teeth involved;

Necessary Follow-up care and Self-Care: I understand that it is important for me to continue to see my regular dentist for routine dental care, as well as to get the crown lengthened tooth/ teeth restore with a filling or crown after the surgery has healed (usually 3 moths, give or take) if that is needed.

I have told my dentist about any pertinent medical condition I have, allergies (especially to medications or sulfites may local anesthetics have sulfite preservatives) or medications I am taking, including over the counter medications such as aspirin.

I will need to come for post-op appointments following my surgery so that healing maybe monitored and so my dentist can evaluate and report on the outcome of surgery to her. Smoking excessive alcohol intake or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important to:

1. Abide by the specific prescriptions and instruction given.
2. See my dentist for post-operative check-ups as needed.
3. Quit smoking
4. Perform excellent oral hygiene once instructed to, usually starting 1 week after the surgery is done.
5. Have my dentist restore the tooth/teeth once the gums are healed.

No warranty or Guarantee: No guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In the most cases, it should be. Due to individual patient differences, however, there can never be a certainty of success. There is a risk of non-success despite the best of care.

Initials_____

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 or in promotional material. My identity will not be revealed to the general public.

Communication with my insurance company, my dentist or other dental/medical providers: I authorize sending correspondence, reports, chart notes, x-rays and other information pertaining to my treatment before, during or after its completion with my insurance carriers, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Female Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.
Procedure(s) to be performed:

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Consent

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling my dentist of any pertinent medical conditions and prescription and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described in this document above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my dentist. I have read and understand this document before I signed it.

_____ _____

Date [Printed name of patient, parent or guardian]

_____

[Signature of patient, parent or guardian]

_____ _____

Date [Printed name of witness]

_____

[Signed name of witness]