Frenectomy Informed Consent

Patient Name | Date of Birth

Treating Doctor | Date

Diagnosis

After a thorough examination, my child's dentist has advised me that the revision of a frenum in my child's mouth may help to restore anatomy, function, and/or prevent commonly associated future problems.

Recommended Treatment

In order to treat this condition, my dentist has recommended that a frenectomy be performed at the selected site or sites. A soft tissue laser will be utilized. This laser is FDA approved for this soft tissue surgery and is an excellent tool to optimize treatment and recovery.

Principle Complications

I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in the minority of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, tenderness, discomfort, damage to adjacent structures such as salivary glands, nerve, muscle or skin. A more common complications is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar, keloid, or overt fibrous tissue formation.

Follow Up

I am advised to return for a 1-2 week follow up on the proposed care.

Alternatives to Suggested Treatment

I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve but may aggravate the surrounding tissues including the gums and teeth. Also, an alternative to a frenectomy by my dentist is to seed the care of another health care professional, including but not limited to doctors of periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

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. I do expect however, that the doctor performs the surgery to the best of her ability.

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ THE FOREGOING SECTIONS AND UNDERSTAND THE TREATMENT TO BE UNDERTAKEN, AS WELL AS THE RISKS, BENEFITS, ALTERNATIVE TREATMENT OPTIONS AND CONSENT TO THE DESCRIBED TREATMENT. THE DENTIST HAS REVIEWED ALL THE TREATMENT OPTIONS WITH ME AND ALL MY QUESTIONS HAVE BEEN ANSWERED.

Parent/Guardian Name (Print)	Parent/Guardian Signature

Provider Name (Print)	Provider Signature	Date

Witness Name (Print)	Witness Signature	Date